Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

Formal meeting, to which members of the public are invited to observe. Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items

10.30am – c.1pm WEDNESDAY 23RD MARCH 2016

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
3-1	To receive apologies for absence	Chairman	Verbal
3-2	To declare interests relevant to agenda items	Chairman	Verbal
3-3	Minutes of the Part 1 meeting of 24th February 2016	Chairman	1
3-4	To note progress with previous actions	Chairman	2
3-5	Review of the Trust Board's Terms of Reference	Chairman / Trust Secretary	3
3-6	Safety moment	Non-Executive Director	Verbal
3-7	Chairman's report	Chairman	Verbal
3-8	Chief Executive's report	Chief Executive	4
3-9	Integrated Performance Report for February 2016 ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. HSMR) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Effectiveness / Responsiveness (incl. DTOCs) ▪ Well-led (workforce)	Chief Executive Chief Nurse Medical Director Dir. of Infect. Prevention and Control Director of Finance Chief Operating Officer Director of Workforce	5
	Presentation from a Clinical Directorate		
3-10	The Integrated Discharge Team	The Integrated Discharge Team	Presentation
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	Planning and strategy		
3-17	Update on the Trust's planning submissions, 2016/17	Director of Finance	12 (to follow)
	Assurance and policy		
3-18	Update from the Senior Information Risk Owner (SIRO) (incl. approval of the IG Toolkit submission for 2015/16)	Chief Nurse	13
	Reports from Board sub-committees (and the Trust Management Executive)		
3-19	Charitable Funds Committee, 22/02/16	Committee Chairman	14
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3-22	Workforce Committee, 03/03/16	Committee Chairman	17
3-23	Pat Exp Cttee, 07/03/16 (incl. revised Terms of Ref.)	Committee Chairman	18
3-24	Trust Management Executive, 16/03/16	Committee Chairman	19
3-25	Finance Committee, 21/03/16	Committee Chairman	20 (to follow)
3-26	**To consider any other business**		
3-27	**To receive any questions from members of the public**		
3-28	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
	Date of next meeting: 27th April 2016, 10.30am, Education Centre, Tunbridge Wells Hospital		

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 24TH FEBRUARY 2016, 10.30 A.M. AT MAIDSTONE HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Gianna Pollero-Payne	Communications Manager	(GPP)
	Sheila Stenson	Deputy Director of Finance (Financial Performance)	(SS)
	David Gazet	Reporter, Kent Messenger (from item 2-3)	(DG)
	Mandy Thompson	Ferring Pharmaceuticals	(MT)

2-1 To receive apologies for absence

Apologies were received from Alex King (AK), Non-Executive Director; and Steve Tinton (ST), Non-Executive Director.

AJ noted that this was PB's last Board meeting, before he left the Trust to become Chief Executive of Kent Community Health NHS Foundation Trust. AJ thanked PB for his contribution, on behalf of the Board, and wished him well in his new role.

2-2 To declare interests relevant to agenda items

There were no declarations of interest.

2-3 Minutes of the Part 1 meeting of 27th January 2016

The minutes were agreed as a true and accurate record of the meeting, subject to the following amendments:

- Item 1-8, page 4 of 12: Replace “The Trust had the second lowest rate of Clostridium difficile in Kent and Medway” with “The Trust had the second lowest rate of Clostridium difficile in Kent, Surrey and Sussex”
- Item 1-8, page 5 of 12: Replace “The trust had committed to provide Trauma training, which would assist with recruitment efforts” with “The Trust had committed to provide Trauma training to the Coastguard Search and Rescue team, and in return the Trust’s staff would have the opportunity to receive reciprocal training, which should help with recruitment efforts for the Trust’s emergency services”

AJ then referred to item 1-11 (page 7), and proposed that AB submit a report to the Trust Board on the process for ensuring there was institutionalised learning following Serious Incidents (SIs). This was agreed. AB stated that she would be able to provide some examples. KT suggested the report

include comments on the Trust's culture. It was agreed to submit a report to the Trust Board meeting in March 2016.

Action: Submit a report to the Trust Board in March 2016 describing the process for ensuring there was institutionalised learning following Serious Incidents (Chief Nurse, March 2016)

2-4 To note progress with previous actions

The circulated report was noted. The following actions were discussed in detail:

- **Item 10-8iii ("Provide Trust Board Members with details of the local healthcare economy schemes being financed via the Better Care Fund").** It was noted that high-level details had been issued to Trust Board Members on 22/02/16, although some further questions had emerged as a result. AJ stated that he would await the response to such questions, but remarked that he did not think the Trust had been sufficiently involved in the Fund. It was however agreed to close the action, as worded.
- **Item 1-12 ("Consider how the number of 'out of hours' patient transfers could be reported to the Trust Board on a regular basis").** AG reported that work was underway, but had not yet concluded. AG reported that it should be possible to provide the requested information for the Board meeting in March 2016.
- **Item 1-19i ("Arrange for the Workforce Committee to review the current list of authorised car and mobile phone users at the Trust").** PB reported that the issue was the agenda for the Workforce Committee in March 2016.

2-5 Safety moment

PS reported that this was the first Board meeting since the conclusion of the Trust's Corporate Manslaughter trial, and he wished to raise two issues: the importance of being able to demonstrate the training and appraisal provided to staff; and the adversarial nature of the trial process, which would have a longstanding impact on the Trust's staff who were directly involved. AJ agreed, and added that the process would have extended the period of pain for the family of Mrs Cappucini.

2-6 Chairman's report

AJ stated that the Board understandably tended to concentrate on the aspects of the Trust that could be improved, but the Board should not forget the aspects that were done well. AJ continued, and thanked the staff who had worked so hard in the face of recent extreme pressures. AJ added that such efforts should be recognised by the Board, and proposed that GD incorporate the Board's sentiments in his next "Chief Executive's update". This was agreed.

Action: Arrange for the weekly "Chief Executive's update" to reflect the Trust's Board's sentiments in recognising the hard work undertaken by Trust staff in response to the recent extreme capacity pressures (Chief Executive, February 2016 onwards)

AJ then tabled a report (Attachment 19) showing the number of cases of post-72 hour Clostridium difficile that had occurred at the Trust between 2006 and 2015, and highlighted that the graph showed the dramatic improvement that had been made year on year. AJ remarked that this was a superb performance, and reflected the contribution by SM and her colleagues in Infection Prevention and Control; but also by the entire staff of the Trust.

2-7 Chief Executive's report

GD referred to the circulated report and highlighted the following points:

- The Board were reminded of the effect of the pressures on emergency services, on both staff and patents, particularly those that the Trust was unable to treat, as a result of the cancellations it had had to make, to ensure emergency activity took priority. GD acknowledged the Trust needed to improve this for the next winter, but emphasised that the financial system in the NHS provided a perverse incentive to prioritise non-emergency care. The Trust was in the midst of contract negotiations for 2016/17, and the aim was to obtain a greater balance.
- When reflecting on the Corporate Manslaughter trial, if it was possible to take anything positive from the experience, it was in hearing the accounts, from the Trust's staff, of a hospital that had

tried everything to try and save Mrs Cappucini. This made GD feel proud, despite the sad circumstances

- The Peggy Wood Foundation had provided funding to purchase equipment for the introduction of an Electromagnetic Navigation Bronchoscopy (ENB) service
- The transfer of some maternity services from East Sussex Healthcare NHS Trust should be considered in the context of the Cumberledge report (the National Maternity Review), and if an initial self-assessment was undertaken against the report's findings, the Trust's services would be regarded as providing a model for what was being recommended. The addition of the Crowborough Birthing Centre cemented the Trust's position even further

AJ requested that the report of the National Maternity Review be circulated to all Trust Board Members. This was agreed.

Action: Circulate the report of the National Maternity Review to all Trust Board Members (Trust Secretary, February 2016)

SDu referred back to GD's first point, and noted that the content of the Trust's website included a comment on the recent capacity pressures, but did not include an apology for, or explanation of, the cancellation of elective procedures that has occurred as a result. It was agreed to update the website with such information.

Action: Arrange for the Trust's website to include an apology for, and explanation of, the cancellation of elective procedures that has occurred as a result of recent non-elective activity pressures (Director of Workforce and Communications, February 2016 onwards)

GD then continued, and paid tribute to fundraiser Hayley Martin, who had passed away in January 2016. GD highlighted that the charity that would be created in reflection of Hayley's wishes would continue her legacy. AJ agreed, and proposed that a list of the main individuals undertaking fundraising activity for the benefit of the Trust be reported to the Trust Board. This was agreed.

Action: Arrange for a list of the main individuals undertaking fundraising activity for the benefit of the Trust to be reported to the Trust Board (Trust Secretary, February 2016 onwards)

2-8 A patient's experiences of the Trust's services

At this point, the Trust Board approved the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from item 2-8 by reason of the confidential nature of the business to be transacted.

[N.B. The minute of item 2-8 will be submitted to the Part 2 meeting of the Trust Board, 23/03/16]

2-9 Review of the Board Assurance Framework, 2015/16

KR referred to the circulated report and highlighted the following points:

- For some objectives, two 'RAG' ratings had been given, but an explanation had been provided
- Following the discussion at the November 2015 Board meeting, the first question posed in the Board Assurance Framework (BAF) document had been changed from "Are the actions that have been taken sufficient to achieve the objective at year-end?" to "Are all of the actions that had been planned for this point been taken?"
- It was agreed at the Audit and Governance Committee on 22/02/16 that the response option label of "Unsure" for the first question should be removed. It was proposed to replace this with "Partially"

Questions or comments were invited. KT remarked that the BAF had been discussed at the Audit and Governance Committee on 22/02/16, and it had been agreed that the BAF should be amended to make it clear that a rating other than 'Green' in response to the question "How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?" should be accompanied by details of the further action planned. GD noted that similar discussions had been held at the Trust Management Executive (TME).

2-10 Integrated Performance Report for January 2016

GD referred to the circulated report and highlighted that there continued to be capacity pressures. AJ then invited AG, AB, SM, PS, PB and SO to highlight any key points.

Effectiveness / Responsiveness (incl. DTOCs)

AG referred to the circulated report and highlighted the following points:

- Performance on the A&E 4-hour waiting time target was 80.4% for the month, and 88.6% for the year to date. January had seen higher activity than previous years, which contributed to the adverse performance
- Length of Stay (LOS) was a key issue, and had prevented the Trust from having an effective flow of patients through its hospitals. Vacancies, which had to be filled by Locums (although there were still some unfilled posts), had an adverse impact on initiatives to reduce LOS
- Delayed Transfers of Care (DTOCs) had continued, and were currently at 6.3%. 141 patients were subject to a DTOC in January

KT asked for a comment on the future performance on the A&E 4-hour waiting time target. AG noted that the new Ward at Tunbridge Wells Hospital (TWH) would enable more referrals to bypass the Emergency Department (ED) and be directed towards an Assessment Unit, which would assist in reducing demand in the ED. KT queried why the future would be any different to this or previous years. AG explained that the Trust did not currently have a fully functioning assessment unit at TWH, and continued that this would be an enabler to managing demand, highlighting that ED patients were being seen within the required times. AG added that once the new Ward was open, there was a commitment to prioritise elective care in certain specialities, including Trauma & Orthopaedics.

AJ asked whether AG was confident that the required A&E 4-hour waiting time target performance could be achieved if DTOCs could be reduced to normal levels (i.e. 3.5%). AG confirmed she had confidence, but this needed to be tested. AG clarified that she was confident in the Trust's internal initiatives. AJ noted that the new Ward would have 39 beds. AG confirmed there would in fact be 38 beds. AJ asked what would therefore prevent the Trust from reaching the required level of performance. AG answered that the Trust would be able to manage for the majority of time, noting that the Trust would be working towards a 90% level of bed occupancy. AJ asked for clarification that the Trust's present plans would not therefore enable maintenance of elective capacity during winter peaks. AG replied that the Trust would need to be mindful of adapting its elective activity during the winter period. GD added that he did not regard the situation as an absolute, but acknowledged that the Trust needed to undertake more elective activity in the summer period. AG noted that if Trauma & Orthopaedics had protected capacity, there would be sufficient capacity (notwithstanding the backlog that had arisen in the recent past).

PS remarked that he was cautious about giving guarantees, but pointed out that the Trust had been successful in discharging patients, and the aforementioned extra beds would provide a major future advantage. GD added that the Trust had little chance of obtaining future capital investment, and any expansion of capacity needed to take place outside of an acute hospital environment, which was an inappropriate location for certain patients.

SDu then referred to AG's earlier comment that some vacancies had an adverse impact on initiatives to reduce LOS, and asked for an explanation. PS replied that a full substantive team of Consultants would be more effective in implementing models of Ambulatory care, and noted that the Trust had shortages of Consultants in some key specialities. SD asked how many Locums were in place compared to permanent posts. PB replied that the Trust had a substantive establishment of 650 Medical staff, and circa 11% were vacant. PS highlighted that not all vacancies were however covered by Locums, as some of affected teams had decided they would rather work around the vacancies.

AG then continued, and highlighted that there was a 12-hour trolley breach ("Emergency A&E >12hr to Admission") on 10/01/16. AG continued that the Root Cause Analysis (RCA) was almost complete, and would be submitted to the SI Panel in due course. AG added that it appeared that the breach was due to a failure of communication, rather than in patient care. AG gave assurance

that the patient involved was kept safe throughout, and added that the patient's relative had sent a note to express their satisfaction during the experience. KT opined that technical solutions should exist to prevent such occurrences. AG replied that a 'flag' had been in place, but human error had also been involved. KT remarked that this should prompt a desire to 'error proof' such systems. AG answered that this was being reviewed.

AG then continued, and highlighted the following points:

- The performance for Cancer access targets for December showed 78% for the 62-day waiting time target (compared to the requirement of 85%)
- For the 104-day waiting time target, there had been 9.5 breaches. RCAs were still underway on such breaches, but AG gave some details of several of the cases involved
- All of the Multidisciplinary Team (MDT) leads were aware of the patients that had exceeded the 62-day waiting time target

AJ welcomed the details provided of the breaches, but highlighted that performance had reduced, and asked why this was the case. AG replied that the main factor was the volume of patients referred to each tumour site i.e. prior to diagnosis. AG continued that once a patient had a diagnosis, they were treated quickly, as was shown by the Trust's performance against the 31-day waiting time target. AG added that the MDT leads had also noted that a number of patients had more complex circumstances, which involved review at more than one MDT meeting. AG summarised that volume of patients and delays in diagnostics were therefore the key factors. AJ asked whether other Cancer Centres had experienced the same issues. AG confirmed this was the case, and GD confirmed the problems were being experienced nationally. AG added that there were backlogs in place at both East Kent Hospitals University NHS Foundation Trust and Medway NHS Foundation Trust, and these would eventually have an impact on the Trust's performance against the 104-day waiting time target. AJ noted that these should be considered separately from the patients originating from the Trust.

SD asked to what the Trust's performance on the 62-day waiting time target equated i.e. if this was not 62 days. AG replied that she could not give a definitive answer, but the largest number of patients were treated between 62 and 72 days. AJ asked AG to keep the Board informed of the situation.

Safe / Effectiveness / Caring

AB then referred to the circulated report and highlighted the following points:

- A Grade 4 Pressure Ulcer had been declared. It involved a sacral Ulcer, and all of the damage occurred in hospital. An external review was underway, at AB's request. The patient involved had chronic pain which meant they preferred to lie in a certain position
- There had been four Grade 3 Pressure Ulcers for the year to date, but this compared favourably with previous years, where there had been 17. There was however further work to do. Mattresses was now the area of focus, as there had been a rise in sacral Pressure Ulcers
- In January 2017, the rate of patient falls (6.1) was the lowest since March 2015.
- Six Mixed Sex Accommodation breaches had been declared, for the first time in 2015/16. The breaches had been identified when end-point validation was undertaken at the Stroke Unit at Maidstone Hospital (MH). The staff believed they had moved all relevant patients, but one had not been moved, so the whole bay had to be declared as a breach.
- Complaints response performance had reduced slightly, which reflected the Directorate's pressures in terms of patient flow
- The Friends and Family Test (FFT) showed a slight reduction in satisfaction score and response rate. However, performance had been good in the context of capacity pressures.

Safe (infection control)

SM then referred to the report and highlighted the following points:

- There had been no cases of Clostridium difficile for the last 2 months, and no cases of MRSA bacteraemia
- The Trust was maintaining its performance on MRSA screening on admissions

- There had been a relatively high number of influenza diagnoses, mostly of the H1N1 strain (swine flu). Six cases had been seen in recent weeks, and the Trust was seeing far more cases than it did during the influenza Pandemic 2 years ago

AJ referred to the latter point, and asked whether the Trust had all the medication it needed. SM confirmed this was the case, and also confirmed that the flu vaccination for that year included protection against swine flu.

Safe / Effectiveness (incl. HSMR)

PS then referred to the circulated report & highlighted that the mortality figures were broadly similar to the previous month, but he could not claim that this was as a result of any particular action.

AJ noted that a new national mortality review process had been issued, which stated that a Mortality Surveillance Group should be accountable to the Board. AJ proposed that the Quality Committee act on behalf of the Board in relation to this requirement. This was agreed.

AB highlighted that the aforementioned guidance had been reviewed to see how the Trust's process compared.

Well-led (workforce)

PB then referred to the circulated report and highlighted the following points:
- January was the seventh month in succession that substantive workforce had increased
- Sickness absence levels had reduced, from the previous month and from same month in the previous year
- Statutory and Mandatory training attendance had been maintained
- Temporary staffing usage was still having an adverse effect, but such usage had a different profile to previous months

KT referred to the "…defined plan of work" in relation to temporary staffing (page 4 of 19), and asked where this was available. PB replied that this arose from a Working Group on the issue, and added that this had been reported to the Finance Committee. KT stated that he could not recall SO referring to this at the Finance Committee. PB confirmed this was his understanding.

Well-Led (finance)

SO then referred to the circulated report and highlighted the following points:
- The financial position had been discussed in detail at Finance Committee on 22/02/16
- There had been an increase in temporary staffing usage in January, which correlated with increased escalation areas
- The worst possible scenario was in place i.e. increasing costs, but reduced income
- The tariff structure meant that the Trust lost money from elective activity as a result of the focus on non-elective activity
- The year to date deficit was £21.97m, which compared to a forecast of no more than £23.5m
- A range of controls were being applied to reduce the deficit at year-end
- The cash position was difficult, but the approval of the "Single Currency Interim Revenue Support Facility") to be considered under item 2-21 would assist

Quality items

2-11 Progress with the Quality Improvement Plan

AJ referred to the circulated report and asked whether the report needed to continue to be received in full, or whether future reports should only include the sections rated something other than 'blue'. It was agreed to have the full report for a further month, and then consider whether future reports should be required at that point.

KT then referred to the "Overnight discharges take place from the ICU" Compliance Action, and asked whether efforts were made to avoid transferring patients with Dementia overnight. PS

confirmed that efforts would be made, but there was no guarantee that such transfers would not take place. AB agreed that this would be considered carefully before any transfers were made.

2-12 Planned & actual ward staffing for January 2016

AB referred to the circulated report and highlighted the following points:

- A&E data had been included for the first time
- Overall, performance was good, but two Wards (Wards 10 and 11) had some instability, which resulted in the issues described in the report

AJ referred to Ward 10, and asked why the "Average fill rate - care staff (%)" tended to exceed plan at night. AB highlighted that the accompanying comments were important in explaining the rationale, including the need for 'Specials'. AJ asked why additional staff were needed at night compared to the day. AB explained that more staff were available during the day, to cover.

AJ asked for further explanation of the situation at CCU at MH and Mercer Ward. AB gave the requested explanation.

KT then expressed a desire to see how much the forward planning was affected by the actual Nursing required, as this was not apparent from the information in the report. SDu added that she would like to see conclusions about the impact of the levels of staffing on, for example, incidents, as the report did not give assurance that Wards had the right levels of staff in relation to patients' acuity. AB replied that when she correlated a year's worth of data, it did not always follow that falls, for example, were related to staffing levels. AB continued that the skill mix of staff had more of an impact, & this was affected by higher levels of temporary staff, and a new influx of overseas staff.

SD remarked that the report did not show the skills that were required, and available, among Nurses, above and beyond the numbers per se. AB agreed, and noted that although the Trust had more 'Specials' in place than ever, each decision was scrutinised closely.

AJ then referred to KT's earlier point, and asked AB whether could provide the information required. KT clarified that he would like AB to submit a report comparing the Nursing establishment for each Ward with the actual staff employed, throughout 2015/16. It was agreed that the requested report would be provided.

Action: Submit a report to the Trust Board comparing the Nursing establishment for each Ward with the actual staff employed, throughout 2015/16 (Chief Nurse, February 2016 onwards)

2-13 Update on the extent of the use, within the Trust, of the clinical information in the 'Dr Foster' IT system

PS referred to the circulated report and highlighted that a technical issue had prevented access to the clinical details of patients subject to alerts within the 'Dr Foster' IT system, but the issue would be resolved over time. KT remarked that if the Trust was not achieving value for money, the relationship with Dr Foster should be reconsidered. PS confirmed that the relationship was being reconsidered.

KT then stated that the key point was to compare how the Trust intended to use the information in the system with how this had actually been used. PS stated that there was acknowledgment that the Trust could do more with the system. KT continued that if the Trust was not using the system effectively, this should be addressed, or the Trust should cease using the system at all. KT clarified that his preference was for the former option.

AB then asked for further explanation as to why the Trust had been unable to access the patient-level data. PS replied he could not explain the intricacies of the problem, but the Head of Performance and Information was in full possession of the facts. It was established that the problem only affected the Trust, as did not affect Dr Foster's other clients. KT suggested that this indicated a refund was due. AJ proposed that representatives from Dr Foster be asked to attend the Quality Committee to provide an explanation. SO proposed instead that he liaise with the Head of Performance and Information, investigate the problems, and provide a report to the Finance

Committee, Quality Committee, or Trust Board. SDu instead proposed that the report be submitted to the TME in the first instance. This was agreed.

Action: Submit a report to the Trust Management Executive, in the first instance, providing an explanation for, and response to, the inability to obtain the clinical details of patients subject to alerts within the 'Dr Foster' IT system (Director of Finance / Medical Director, April 2016)

Other matters

2-14 Findings of the national staff survey 2015

PB referred to the circulated report and gave a presentation highlighting the following points:

- There were now 32 key findings, instead of the 29 in previous surveys
- Further analysis and debate would be held at the next meeting of the Workforce Committee, before a detailed response was submitted to the Trust Board in April 2016
- There had been a reduced response rate compared to last year, at 41%, although this was at the national average
- The Trust had improved results when compared to its performance on the 2014 survey, and also when compared against the benchmark of acute Trusts in England
- Of the 32 key findings, 15 were better than average, 10 were average, and 7 were worse than average
- Of the 13 'at a glance' findings, 7 were better than the acute national average, 5 were at the average, and 1 was worse than the average
- Of the top 5 ranking scores, staff gave a view that what they did made a difference, and although reported appraisal had reduced slightly, this was still far above the average. Less staff also reported seeing harmful errors
- In 2014, 4% of staff had reported seeing physical violence, but following action, this had reduced, to 1%
- The bottom ranking scores included staff reporting working extra hours (but being paid for such hours)
- There were still too many staff experiencing abuse from patients or relatives. There was also an issue regarding discrimination, and there were challenges regarding communication and looking after the health and wellbeing of staff
- However, none of the bottom ranking scores showed a marked deterioration from the previous survey
- A press release would now be issued, and further discussions would be held

KT referred to "KF7" ("Staff ability to contribute towards improvements at work"), and commented that recent discussions had been held in relation to the introduction of a "Stop, Start, Simplify" approach, which could assist with efforts to improve. KT also noted that the "Safety moment" that ST had given at the most recent Finance Committee meeting was related to staff wellbeing, and suggested that the wider introduction of "safety moments" may have a beneficial effect. The comments were acknowledged.

KT then asked whether the term "senior managers" (which featured under the "Your managers" section) was defined. PB replied that it was up to the staff member to interpret who this was.

AJ commended the Executive Team as a whole for the performance. PB stated that he believed the performance was a testament to the Trust's staff.

Planning and strategy

2-15 Progress on the liaison with KCC re the development of a Vanguard scheme (to address DTOCs: Update

JL referred to the circulated report and highlighted the following points:

- The report related to the discussions held earlier in the meeting regarding DTOCs and capacity, and also to a meeting that had been held in December 2015 with Greg Clark MP
- The report highlighted that there was no single leadership in place at system level

- In the medium term, it had been acknowledged that there was a lack of capacity in the overall system, and although discussions had been held since he joined the Trust, it was now appropriate to have a succinct approach to determining the size of the capacity gap, and the specific needs
- JL had discussed the contents of the report in more detail with colleagues at Kent County Council and West Kent Clinical Commissioning Group
- The Board was being asked to support the proposals on page 1 of 3

AJ stated that he would like a 'straw man' to be produced by the Trust, to prompt action from other stakeholders. JL noted that he had already developed a 'straw man'. AJ asked whether this could be shared with the Trust Board. JL agreed to circulate this to all Trust Board Members.

Action: Circulate, to all Trust Board Members, the 'straw man' that has been developed to aim to improve flow/discharge, and address the capacity gap within the West Kent health and social care system (Deputy Chief Executive, February 2016 onwards)

JL then continued, and highlighted that in the short-term, it was possible that beds would soon become available at Sevenoaks Hospital, and Commissioners had indicated a willingness to use this capacity differently. JL stated that he believed there were circa 15-20 beds, but discussions were not yet complete (although the Trust was pursuing the matter with some urgency). JL added that the opportunity had potential, and the Trust therefore needed to consider this.

2-16 Update on the development of the Sustainability and Transformation Plan (STP) for Kent and Medway

JL referred to the circulated report and highlighted the following points:

- A Sustainability and Transformation Plan (STP) was required to be submitted in July 2016
- The 'footprint' for the STP had been confirmed, by NHS England, as 'Kent and Medway'

SDu asked whether the Trust had been involved in the consideration of the defined footprint. JL confirmed that the footprint had been set without the Trust's involvement, but added that this did not prevent the Trust considering the options available via a different geographical corridor. SDu proposed that the Trust's submissions should be caveated with this particular point. JL pointed out that he was due to submit a final version of the Trust's Strategic direction to the Board in April 2016, and the point would be reflected in that document.

Assurance and policy

2-17 Compliance oversight self-certification

KR referred to the circulated report and highlighted the following points:

- The NHS Trust Development Authority (TDA) had emailed Trusts to state that they were no longer required to self-certify
- Given this, and the recent "Stop, Start, Simplify" approach that has been discussed at the Finance Committee and Trust Board, it was proposed that the Self-Certification exercise cease after February 2016. The Board was therefore asked to consider the proposal

It was agreed that the compliance oversight self-certification exercise should cease after the February 2016 Trust Board meeting.

2-18 Ratification of Standing Orders (ann. review)

KR referred to the circulated report and highlighted the following points:

- The document was the third of a suite of three, which also included the Standing Financial Instructions and Reservation of Powers and Scheme of Delegation
- The proposed changes were self-explanatory, and were shown as 'tracked' in the document
- The changes had already been discussed at the Audit and Governance Committee

The Standing Orders were ratified as circulated.

Reports from Board sub-committees (and the Trust Management Executive)

2-19 Quality Committee, 01/02/16

SDu referred to the circulated report and highlighted the following points:

- The findings from the National Clinical Audits relating to Cancer were reviewed
- A review of compliance with the statutory Duty of Candour had been undertaken, and SDu had expressed some regret that this had been reduced to a largely process driven issue, rather than reflecting the underlying principle of candour

AB referred to SDu's latter comment, and noted that a process was required to demonstrate evidence. AJ agreed this was relevant but not sufficient.

2-20 Trust Management Executive, 17/02/16 (incl. ToR)

GD referred to the circulated report and highlighted that it was noted that the Care Quality Commission would be undertaking a further round of inspections of Cancer Centres, so the Trust would therefore be inspected at some future point. AG noted that an indicative timing had been suggested of June and July 2016.

2-21 Finance Committee, 22/02/16 (incl. approval of the Business Case re the transfer of Crow. Birthing Centre & High Weald Comm. Midwifery; & the Trust's revised application for a "Single Currency Interim Revenue Support Facility")

SDu referred to the circulated report (Attachment 16) and highlighted the following points:

- The Trust's revised application for a "Single Currency Interim Revenue Support Facility" had been supported
- The Outline Business Case (OBC) for additional Radiotherapy Linear Accelerator (LinAc) bunker capacity at TWH was supported
- The Business Case for the transfer of Crowborough Birthing Centre & High Weald Community Midwifery Services was supported.

SDu referred to the latter point, and added that the recent announcement regarding maternity budgets had not been discussed. GD stated that he believed the announcements were supportive of the direction of travel brought about by the transfer.

SDu then continued, and highlighted that The Finance Committee remained concerned at the difficulty in explaining why staff numbers had increased at a greater rate than increases in activity.

AJ then referred to Attachment 17 and asked for comments or queries. None were received.

The Business Case regarding the transfer of Crowborough Birthing Centre & High Weald Community Midwifery was approved as circulated.

SO then referred to Attachment 18 and highlighted that the Deputy Director of Finance (Financial Governance) had identified that the Trust's PFI meant that the Trust had access to an increased facility. AJ asked for comments or queries. None were received.

The revised application for a Single Currency Interim Revenue Support Facility was approved as circulated. Specifically, the Trust Board resolved that:

- The terms of, and the transactions contemplated by, the Finance Documents to which Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "£16,908,000 Single Currency Interim Revenue Support Facility Agreement") be approved
- The Finance Documents to which Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "£16,908,000 Single Currency Interim Revenue Support Facility Agreement") be executed
- The Director of Finance be authorised, on behalf of the Trust Board, to execute the Finance Documents to which Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "£16,908,000 Single Currency Interim Revenue Support Facility Agreement")
- The Director of Finance and the Deputy Directors of Finance be authorised, on behalf of the Trust Board, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the

Finance Documents to which Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "£16,908,000 Single Currency Interim Revenue Support Facility Agreement").

- The Direct Debit form (which forms part of the documents referred to in the point above) be signed by two signatories from the current Authorised Signatory panel held by the Department of Health Cash funding team (i.e. the Trust's Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems).
- Maidstone and Tunbridge Wells NHS Trust undertook to comply with the Additional Terms and Conditions listed within the "£16,908,000 Single Currency Interim Revenue Support Facility Agreement"

2-22 Charitable Funds Committee, 22/02/16

SDu reported the following points:

- The outgoing Head of Financial Services had attended for the final time, and was commended for her contribution
- The Committee heard about the plans to spend funds, but noted that these needed to be closely monitored

2-23 Audit and Governance Committee, 22/02/16

KT reported the following points:

- The meeting had been straightforward
- The BAF and Risk Register had been reviewed
- The were no significant issues arising from Internal Audit review reports
- The Single Tender Waivers were reviewed as usual

2-24 To consider any other business

SDu referred to the aforementioned Corporate Manslaughter trial, and asked whether the Trust would seek to recover its legal costs, in the light of the outcome. GD replied that this was being considered, but pointed out that the eligibility threshold for cost recovery was high, as the Crown Prosecution Service (CPS) case needed to be shown to be negligent. PB added that a submission had been made by the Trust, and a response had been received from the CPS, but clarified that the Trust could only seek recovery of its costs from the point of being charged with the offence.

SDu then referred to the general disaffection felt by Junior Doctors, and asked what action the Trust was taking in response. PS replied that a number of meetings had been held with Junior Doctors, to ensure that any industrial action proceeded without risks to patient harm, but emphasised that the Trust had limited ability to influence global satisfaction levels. AJ added that the Trust had a duty to ensure that communication of the imposed contract settlement was understood by its Junior Doctor employees. GD agreed. PB appealed for Trust Board Members to listen to any concerns raised by Junior Doctors during Ward or Departmental visits they undertook. AG added that there were a number of forums at which Junior Doctors views were already heard.

2-25 To receive any questions from members of the public

There were no questions.

2-26 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – March 2016

3-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	The Medical Director notified the Trust Board on 25/11/15 that he would be unable to provide the requested information until March 2016
1-12 (Jan 16)	Consider how the number of 'out of hours' patient transfers could be reported to the Trust Board on a regular basis	Chief Operating Officer	January 2016 onwards	The data collection is being developed, via the Head of Performance and Information, but is not yet ready to be reported
1-19ii (Jan 16)	Revise the Reservation of Powers and Scheme of Delegation to reflect the amendments made at the Trust Board on 27/01/16	Trust Secretary	January 2016 onwards	The amendments will be made in March 2016
2-15 (Feb 16)	Circulate, to all Trust Board Members, the 'straw man' that has been developed to aim to improve flow/discharge, and address the capacity gap within the West Kent health and social care system	Deputy Chief Executive	February 2016 onwards	In progress

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
1-19i (Jan 16)	Arrange for the Workforce Committee to review the current list of authorised car and mobile phone users at the Trust	Director of Workforce and Communications / Chairman of Workforce Committee	March 2016	The Workforce Committee were provided with information on the remaining lease cars in the organisation and the work programme underway to reduce the number of mobile phones (03/03/16)
2-3 (Feb 16)	Submit a report to the Trust	Chief Nurse	March	A report has been

[1] Not started | On track | Issue / delay | Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	Board in March 2016 describing the process for ensuring there was institutionalised learning following Serious Incidents		2016	submitted to the March 2016 Trust Board
2-6 (Feb 16)	Arrange for the weekly "Chief Executive's update" to reflect the Trust's Board's sentiments in recognising the hard work undertaken by Trust staff in response to the recent extreme capacity pressures	Chief Executive	February 2016	The content of Chief Executive's Update on 26th February 2016 reflected the Trust's Board's sentiments
2-7i (Feb 16)	Circulate the report of the National Maternity Review to all Trust Board Members	Trust Secretary	February 2016	The report was circulated by email on 24/02/16
2-7ii (Feb 16)	Arrange for the Trust's website to include an apology for, and explanation of, the cancellation of elective procedures that has occurred as a result of recent non-elective activity pressures	Director of Workforce and Communications	February 2016	The Trust website was updated
2-7iii (Feb 16)	Arrange for a list of the main individuals undertaking fundraising activity for the benefit of the Trust to be reported to the Trust Board	Trust Secretary	March 2016	A list of the individual fundraisers recorded on the Charitable Fund's "Just Giving" website page is enclosed, in Appendix 1
2-12 (Feb 16)	Submit a report to the Trust Board comparing the Nursing establishment for each Ward with the actual staff employed, throughout 2015/16	Chief Nurse	March 2016	The requested information has been included in the 'Planned V Actual' Ward staffing report submitted to the March 2016 Trust Board

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
2-13 (Feb 16)	Submit a report to the Trust Management Executive, in the first instance, providing an explanation for, and response to, the inability to obtain the clinical details of patients subject to alerts within the 'Dr Foster' IT system	Director of Finance / Medical Director	April 2016	A report has been scheduled for the TME in April 2016 (although an explanation was provided at the 'main' Quality Committee on 02/03/16)

Appendix 1: List of the main individuals undertaking fundraising activity for the benefit of the Trust (as listed on the "Just Giving" website pages for the Charitable Fund - www.justgiving.com/mtwnhscharitablefund)

Fundraiser	Event	Benefitting Department / Ward
Gill Bruce	56 miles sponsorship cycle ride 01/05/16	Neonatal TWH
Rachel Burns	To purchase a Vapotherm Unit - taking on a different challenge every month starting January 2016 and continuing until December, to include cycling 50 miles, walking a marathon, 5km open water swim.	Neonatal TWH
Lee Durden	Virgin London Marathon 24/04/16	Hedgehog Ward
Alice Francis	Morrison's Great South Run 25/10/15	Hedgehog Ward
Richard Selvey	Skydive 24/09/16	Neonatal TWH
Kirsty Scott	'Smashing it for Smithers' - General fundraising , started with a charity bike ride in August 2013, 400 miles over 5 days and continues with various activities, e.g. wedding bar donations, pub quiz. Pretty Muddy event at Mote Park on the 12/07/16	Oncology
Kate Spanier	In memory of Jacob Spanier - General fundraising target of £10k	Neonatal TWH

N.B. The above list does not include the large number of individuals who undertake fundraising via the League of Friends of Tunbridge Wells Hospital and the League of Friends of the Maidstone Hospital.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-5 Review of the Trust Board's Terms of Reference Chairman / Trust Secretary

The Terms of Reference for the Trust Board are required to be reviewed and approved at least every 12 months. This review and approval last took place in November 2014, and is therefore now overdue.

The Terms of Reference have therefore been reviewed, and a number of minor amendments are proposed. These have been 'tracked' in the enclosed. None of the proposed amendments are significant, and can largely be categorised as 'housekeeping', to reflect changes that have already been agreed, or occur in practice.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Approval

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board

Terms of Reference

Purpose and duties

1. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health'.

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to an Executive Director. The Trust Board consists of a Chairman (Non-Executive), five other Non-Executive Directors (voting members), the Chief Executive, and four Executive Directors (voting members). Other Directors (non-voting) also attend the Board, and contribute to its deliberations and decision-making.

3. The Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

5. The practice and procedure of the meetings of the Trust Board – and of its Committees – ~~are not set out here but~~ are described in the Trust~~Board~~'s Standing Orders ~~and Code of Conduct~~.

General responsibilities

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders ~~service users, carers, local health organisations, local government authorities and~~ others to provide safe, accessible, effective and well governed services for the Trust's patients ~~and carers~~;
   6.2. To ensure that the Trust meets its obligations to the population served~~, its stakeholders~~ and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of Non-Executive and Executive Directors.

Leadership

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

Strategy

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;

9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;
9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
9.4. Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A Board Code of Conduct has been developed to guide the operation of the Trust Board and the behaviour of Trust Board Mmembers.

Governance

12. The Trust Board:
12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that ~~the~~ resources ~~vested in the Trust~~ are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
12.2. Ensures that the Trust complies with its governance and assurance obligations ~~in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences~~;
12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
12.4. ~~Formulates, implements and~~ Rreviews and ratifies Standing Orders, Scheme of Delegation and Standing Financial Iinstructions as a means of regulating the conduct and transactions of Trust business;
12.5. Ensures that the statutory duties of the Trust are effectively discharged;
12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk Management

13. The Trust Board:
13.1. Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to ~~the development of care plans,~~ the review of quality of services provided and the development of new services;
13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Executive Directors.

Ethics and integrity

14. The Trust Board:
14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
14.2. Ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time

Communication

16. The Trust Board:
    16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
    16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
    16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
    16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality Success and Financial success

17. The Trust Board:
    17.1. Ensures that the Trust operates effectively, efficiently, economically;
    17.2. Ensures the continuing financial viability of the organisation;
    17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
    17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
    17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chairman

18. The Chairman of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chairman is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chairman is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the ~~Board~~ Chairman of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

~~Board~~ Membership of the Trust Board

24. The Board will comprise ~~of~~ the following persons:
    24.1. A Non-Executive Chairman
    24.2. Non-Executive Directors (5). One of these will be designated as Vice Chairman
    24.3. The Chief Executive
    24.4. The Director of Finance
    24.5. The Medical Director
    24.6. The Chief Nurse
    24.7. The Chief Operating Officer

Non-voting Board Members will be invited to attend at the discretion at the Chairman.

Quorum

25. The Board will be quorate when four of the Board Members~~membership~~ including at least the Chairman (or Non-Executive Director nominated to act as Chairman), one other Non-Executive Director, the Chief Executive (or Executive Director nominated to act as Chief Executive), and one other Executive Director (member) are present~~in attendance~~.

Attendance

26. The Trust Secretary will attend each meeting.

27. Other staff members and external experts may be attend the Board to contribute to specific agenda items, at the discretion of the Chairman

Frequency of meetings

28. The Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chairman.

Board development

29. The Chairman, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a “balanced board” where the skills and experience available are appropriate to the challenges and priorities faced;

30. Trust Board M~~m~~embers will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

31. The Trust Board has the following sub-committees
    31.1. The Quality ~~& Safety~~ Committee
    31.2. The Patient Experience Committee
    31.3. The Audit and Governance Committee
    31.4. The Finance Committee
    31.5. The Workforce Committee
    31.6. The Foundation Trust Committee
    ~~31.7. The Finance Committee~~
    ~~31.8.~~31.7. The Remuneration and Appointments Committee

32. For the Quality Committee, Patient Experience Committee, Audit and Governance Committee, Finance Committee, and Workforce Committee, a~~A~~ summary report from each meeting will be provided to the Trust Board (by the C~~c~~hairman of that meeting) in a timely manner

33. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

Emergency powers and urgent decisions

34. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman of the Trust Board after having consulted at least two Non-Executive Directors.

35. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session (Part 1) for formal ratification.

Administration

~~33.~~36. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:

~~33.1.~~36.1. Agreement of the agenda for Trust Board meetings with the Chairman and Chief Executive;

~~33.2.~~36.2. Collation of reports for Trust Board meetings;

~~33.3.~~36.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;

~~33.4.~~36.4. Advising the Trust Board on governance matters.

~~34.~~37. A full set of papers comprising the agenda, minutes and associated reports ~~and papers~~ will be sent within the timescale set out in Standing Orders to all Trust Board Members~~Directors~~ and others as agreed with the Chairman and Chief Executive from time to time.

Conflict with Standing Orders Set

38. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

Review

~~35.~~39. These Terms of Reference will be reviewed and approved at least every 12 months.

Approved by the Trust Board, 26th November 2014
Approved by the Trust Board, 23rd March 2016

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - March 2016

3-8 Chief Executive's update Chief Executive

I wish to draw the points detailed below to the attention of the Board:

1. A national report has rated our organisation as `Good' for the open and transparent way in which we identify errors and collectively learn from our mistakes to improve patient care.

   The rating is part of a new national drive by the NHS to chart the importance care providers place on creating an open and honest environment that encourages staff to raise and resolve clinical issues.

   The annual rating is reached by comparing different data sources. This includes feedback from our own staff, via the recent national NHS staff survey, which asked NHS employees if they reported errors or near misses. In all, 92% of our staff who took part in the survey said they did. Providers are also seen as taking an open and proactive stance on improving patient safety if they appropriately report incidents to the national NHS database, which we do.

   Looking ahead, our aim is to achieve the `Outstanding' rating in next year's review. I will continue to focus on key areas of clinical governance in my Board paper to support this approach publicly and in my work with colleagues throughout our organisation.

   I have challenged our staff and clinical colleagues to be even more proactive by questioning the care patients receive if they feel this can be improved. 94% of our colleagues who took part in the national staff survey said their role makes a difference to patients. By working openly and closely together we can continue to raise standards of care and safety.

2. I have shared our quality and safety priorities for the coming year with colleagues as part of my on-going efforts to promote clinical governance and patient wellbeing. To improve quality it is our aim to embed our new governance structures, continue to focus on patient falls and develop our mortality surveillance processes. To improve safety, we are going to focus on improving our handover process, effectiveness of identifying and acting upon changes during normal labour and birth, and improve the quality of our patient involvement in decision making.

3. We are due to open our new Acute Medical Unit (AMU) at Tunbridge Wells Hospital (TWH) and complete associated ward moves on 19th and 20th of March. The AMU will have three subsections

   i) Ambulatory Emergency Care with 2x4 bedded bays for trolleys and chairs for A&E/GP Referrals
   ii) Treatment Suite with 2x4 bedded bays for patients who return for procedures e.g. lumbar punctures, infusions, blood transfusions, chest X-ray. This will assist early discharge or prevent admission
   iii) Inpatient Area with 22 inpatient beds for non-elective short stay medical admissions.

   This development reflects models of national best practice in patient care and helps fast-track through key elements of West Kent Clinical Commission Group's recent urgent care strategy. The development will also enable us to move stroke rehabilitation services from Tonbridge Cottage Hospital to TWH and create an Elderly and Frailty Ward.

   We remain on schedule to take over the management of Crowborough Birth Centre and community midwifery care in the High Weald area of north East Sussex on 1st April.

4. We are among the first trusts to benefit from a new national maternity fund to provide even safer services locally and nationally. We have received £16,000 for simulation equipment to help midwives learn about and practice a range of labour and birth scenarios.

5. A unique scheme run by our Trust that helps safeguard care standards for patients throughout the South East has become the first of its kind to receive ISO accreditation in England. Our external equality assurance (EQA) scheme for general histopathology checks slides of biopsies and other specimens to provide assurance about the quality of diagnosis for patients across the South East.

6. We have teamed up with leading breast cancer charities Breast Cancer Now and Breast Cancer Care to help improve services for local people diagnosed with incurable secondary breast cancer. Our `pledge' to make a range of patient-led service improvements includes streamlining referrals to counselling services to provide emotional support for patients and relatives. In another move to improve patient care, we now run specialist clinics for patients with secondary breast cancer. This has increased recruitment to clinical trials by 50%.

7. The project to implement the new Allscripts PAS is now well underway and we are on track for a go-live this summer. This is an exciting project for the Trust and underpins our Informatics strategy which will enable us in the future to move away from paper to a single and unified view of patients' clinical information on a computer screen.

8. Our advanced trauma life support courses have been singled out by the Royal College of Surgeons from 100 other providers as delivering consistently very high quality training in the NHS. Mr Guy Slater, one of our course directors, and Mr Justin Forder, were invited to speak at the Royal College, sharing information about the way we deliver the course.

9. A regional review of pain assessment in intensive care has shown that Tunbridge Wells Hospital's ICU practice for both doctors and nursing assessment, and documentation of pain, was one of the best centres in the study. The national Society for Acute Medicine Benchmarking Audit has shown that 97% of patients had a review by a competent decision maker within four hours of admission (the Trust performed better than the national average of 87%). We are also fully compliant with key investigations being carried out within the audited timeframe.

10. I would like to place on record my on-going thanks to the League of Friends at both Maidstone and Tunbridge Wells hospitals. Friends of TWH have now confirmed that Diane Barber's 25th consecutive Christmas coffee morning raised £4,458.

11. Our latest staff and team of the month awards have gone to Dr Ravish Mankragod and Gaynor Gibbons for overseeing the set-up and delivery of the new respiratory ward, John Day, at Maidstone Hospital. Staff from John Day Ward picked up team of the month for their hard work in ensuring the smooth running of the ward.

    I also presented Amanda Clinch, ward clerk on the Surgical Assessment Unit at Tunbridge Wells Hospital, with an individual of the month award. Her nomination mentions Amanda's excellent communication skills with patients and staff, her proactive approach to work and her willingness to help and go above and beyond her role, which is all helping to improve the patient experience.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
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Trust Board meeting – March 2016

3-9 Integrated Performance Report for February 2016	Chief Executive / Executive Team

The enclosed report includes:

- The 'story of the month' for February, which includes the latest position on Delayed Transfers of Care (DTOCs)
- The Trust performance dashboard
- Integrated performance charts
- Financial performance overview
- Finance 'pack'

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 15/03/16

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Discussion and scrutiny

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

'Story of the month' for February 2016

As per previous board reports the key areas of emergency access, low levels of elective activity and cancer performance remain our focus.

A&E attendances show a huge increase above last year's levels with an increase of 21.8% (17.6% when adjusted for leap year) with activity at Maidstone being up by 27.8%. This resulted in an average of 396 attendances per day, the highest level recorded. Attendances at assessment units, particularly for children were also very high at 17 % above previous year.

Non-elective admissions only rose by 2.0% compared to last year (adjusted for leap year) and the level of delayed transfers of care high at 5.8% of all beds with an ongoing increase in the proportion of patients now being patients awaiting nursing home placement and continuing health care.

The average non-elective length of stay (LOS) remained high at 7.7 days, whilst average occupancy increased to record levels at 728 patients a night (excluding Romney Ward). This is at odds with previous year's pattern for January and February which, if it continues, would suggest occupancy for March will also be high.

The Referral to Treatment (RTT) performance has been delivered for February but the number of patients waiting over 18 weeks has increased as a result of the drop in the levels of elective activity, 24% down on the previous year. However with the development of the new ward at TWH we aim to increase the levels of elective activity incrementally through quarter 1, returning to normal levels as quickly as possible across all specialties.

The performance on Cancer targets in January (reported a month in arrears) shows a continued underperformance on the 62 day target at 69.5% and the 2 week-wait target at 90.4%. There were 6.5 breaches of the 104 day target down from the previous month. The 62 day position for patients managed entirely by MTW was better at 75.8% for January. The majority of cancer two week wait breaches are due to patients choosing dates outside of breach. 50% of patients are offered an appointment before day 10 despite the volumes of cancer referrals increasing.

There were no Clostridium difficile cases in February holding the year to date figure to 17 and only allowing for a maximum of 4 cases in March. There were no MRSA cases in February.

There was an increase in pressure ulcers with the monthly rate slightly above plan. There is no obvious cause for this increase and the year to date position is still better than plan. The actions being taken to improve the position are detailed within the quality report.

The number of falls remained stable at 133 in February which, when combined with the high level of occupancy, meant and the rate stayed below the long term average and on plan. There were no falls resulting in serious harm in February.

Complaints received by the Trust increased in February previous three months low numbers. The actions being taken to get back to 75% of complaints being responded to within 25 days are detailed in the quality report.

Workforce

During the month the Trust continued its recruitment performance and now employs 5,119 whole time equivalent substantive staff, as with the previous months this is an increase of 60 WTE compared with December 2015. This is the highest number of substantive staff employed by the Trust since reporting to the Board became the norm and represents a net increase of over 160 WTE against the same month last year. The month sees a net increase (25 WTE) in the numbers of substantive registered nurses and an increase of 7 WTE clinical support workers. Over the next few months the 'pipeline' of recruitment for registered nurses should enable the continued reduction in nurse vacancies with expected monthly net increases. However, despite the

recruitment success the dependence upon temporary staff remained higher than planned and further work is ongoing to ensure, in line with the TDA requirements, we reduce our dependence upon expensive agency and interim workers. A task and finish group has been established to focus on medical recruitment, and has a defined plan of work.

Sickness absence in the month was 3.7%, representing a significant improvement on the same period last year and on the last month. and whilst not all areas of the Trust are consistently achieving the required levels of appraisal and statutory and mandatory training actions are in place to do so within the year.

TRUST PERFORMANCE DASHBOARD **Position as at:** **29 February 2016**

Governance (Quality of Service): **2.0** **Amber/Red** Based on TDA 2014/15 Methodology

Finance: **TDA** **Amber**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains

******A&E 4hr Wait is Quarter to date, Forecast is for Quarter 4 only

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	*Rate C-Diff (Hospital only)	15.51	0.0	11.8	7.7	-4.0	- 3.6	11.5	7.9	
'1-02	Number of cases C.Difficile (Hospital)	1	0	25	17	-8	- 8	27	19	
'1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	1	0	1	
'1-04	Elective MRSA Screening	99.0%	98.0%	99.0%	98.0%		0.0%	98.0%	98.0%	
'1-05	% Non-Elective MRSA Screening	99.0%	98.0%	99.0%	98.0%		3.0%	95.0%	98.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.1	3.9	2.3	2.8	0.5	- 0.3	*3.0*	2.7	3.0
'1-07	***Rate of Total Patient Falls	6.4	6.2	6.2	6.7	0.4	0.5	*6.2*	6.6	
'1-08	***Rate of Total Patient Falls Maidstone	5.8	6.1	5.1	6.1	1.0			6.1	
'1-09	***Rate of Total Patient Falls TWells	6.9	6.6	7.0	7.0	- 0.0			7.0	
'1-10	Falls - SIs in month		0		41	41				
'1-11	Number of Never Events	1	0	2	2	0	2	*0*	2	
'1-12	Total No of SIs Open with MTW	21	34			13				
'1-13	Number of New SIs in month	10	6	102	95	- 7	- 15			
'1-14	**Serious Incidents rate	0.52	0.28	0.48	0.43	- 0.05	0.37	*0.0584 - 0.6978*	0.43	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.68	0.48	1.13	1.13	- 0.00	- 0.10	*0 - 1.23*	1.13	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
'1-17	VTE Risk Assessment	95.8%	95.1%	95.6%	95.4%	-0.2%	0.4%	95.0%	95.4%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.8%	96.1%	96.6%	96.7%	0.1%	1.7%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	1.40%	3.06%	2.50%	2.48%	-0.02%	-0.52%	*3.00%*	2.48%	
'1-20	C-Section Rate (non-elective)	15.9%	13.3%	15.2%	12.9%	-2.29%	-2.14%	*15.0%*	12.9%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		103.4	103.0	- 0.4	3.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	105.0	- 1.9	5.0			100.0
2-03	Crude Mortality	1.4%	1.1%	1.1%	1.2%	0.1%				
2-04	****Readmissions <30 days: Emergency	11.6%	9.7%	11.7%	11.1%	-0.5%	-2.5%	*13.6%*	11.1%	14.1%
2-05	****Readmissions <30 days: All	11.0%	9.4%	10.9%	10.4%	-0.5%	-4.3%	*14.7%*	10.4%	14.7%
2-06	Average LOS Elective	2.8	3.4	3.2	3.2	0.0	0.0	*3.2*	3.2	
2-07	Average LOS Non-Elective	7.5	7.7	6.8	7.4	0.5	0.9	*6.5*	7.4	
2-08	New:FU Ratio	1.62	1.48	1.54	1.46	- 0.08	- 0.06	*1.52*	1.52	
2-09	Day Case Rates	86.6%	86.0%	83.7%	84.3%	0.6%	4.3%	80.0%	84.3%	82.2%
2-10	Primary Referrals	8,417	8,790	92,854	96,007	3.4%	1.8%	94,755	104,811	
2-11	Cons to Cons Referrals	3,206	2,492	37,422	37,250	-0.5%	2.7%	39,585	40,666	
2-12	First OP Activity	10,884	11,434	131,032	127,875	-2.4%	1.5%	137,569	139,602	
2-13	Subsequent OP Activity	20,739	21,698	237,082	239,221	0.9%	0.1%	260,989	261,158	
2-14	Elective IP Activity	644	522	6,999	6,948	-0.7%	-5.0%	7,988	7,585	
2-15	Elective DC Activity	3,021	3,046	34,127	35,536	4.1%	0.6%	38,556	38,795	
2-16	Non-Elective Activity	3,531	3,788	43,116	41,457	-3.8%	-6.2%	48,289	45,293	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	9,214	11,636	119,249	126,425	6.0%	1.6%	135,922	138,124	
2-18	Oncology Fractions	5,373	5,793	64,093	63,169	-1.4%	-3.8%	71,761	69,014	
2-19	No of Births (Mothers Delivered)	421	475	5,201	5,282	1.6%	0.9%	5,708	5,762	
2-20	% Mothers initiating breastfeeding	82.9%	74.3%	81.7%	77.6%	-4.2%	-0.4%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.0%	0.42%	0.26%	0.41%	*0.1%*	*-0.1%*	*0.47%*	0.41%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	68	6	-62	6	0	6	
3-02	*****Rate of New Complaints	2.53	2.79	4.10	2.15	-1.94536	0.83	*1.318-3.92*	2.14	
3-03	% complaints responded to within target	75.0%	54.8%	75.0%	74.2%	-0.8%	-0.8%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	New	82.2%	New	82.9%	New	7.9%	75.0%	75.0%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	New	95.6%	New	96.4%	New	1.4%	95.0%	95.0%	95.7%
3-06	A&E Friends & Family (FFT) % Positive	New	85.8%	New	88.6%	New	1.6%	87.0%	87.0%	86.9%
3-07	Maternity Combined FFT % Positive	90.0%	93.2%	90.6%	95.0%	4.4%	0.0%	95.0%	95.0%	95.5%
3-08	OP Friends & Family (FFT) % Positive	New	81.7%	New	80.0%	New			80.0%	

* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	88.0%	82.6%	92.2%	81.5%	-10.8%	-13.5%	95.0%	82.7%	90.1%
4-02	Emergency A&E >12hr to Admission	0	0	2	1	-1	1	*0*	1	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	18 week RTT - admitted patients	90.2%	92.5%	91.5%	90.5%	-1.0%	0.5%	90%	90.5%	
4-06	18 week RTT - non admitted patients	97.9%	96.2%	96.9%	97.5%	0.5%	2.5%	95%	97.5%	
4-07	18 week RTT - Incomplete Pathways	96.6%	92.0%	96.6%	92.0%	-4.5%	0.0%	92%	92.0%	
4-08	18 week RTT - Specialties not achieved	7	13	26	71	45	71	*0*	71	
4-09	18 week RTT - 52wk Waiters	1	0	0	5	5	5	*0*	5	
4-10	18 week RTT - Backlog 18wk Waiters	524	1,297	524	1,297				1,297	
4-11	% Diagnostics Tests WTimes <6wks	99.9%	99.8%	100.0%	99.8%	-0.2%	0.8%	99.0%	99.0%	
4-12	*Cancer WTimes - Indicators achieved	8	1	8	1	- 7	- 8	9	9	
4-13	*Cancer two week wait	95.5%	90.4%	95.5%	90.4%	-5.0%	-2.6%	93.0%	90.4%	
4-14	*Cancer two week wait-Breast Symptoms	94.4%	87.1%	94.4%	87.1%	-7.3%	-5.9%	93.0%	93.0%	
4-15	*Cancer 31 day wait - First Treatment	97.8%	94.5%	97.8%	94.5%	-3.3%	-1.5%	96.0%	94.5%	
4-16	*Cancer 62 day wait - First Definitive	75.9%	69.5%	75.9%	69.5%	-6.3%	-15.5%	85.0%	69.5%	
4-17	*Cancer 62 day wait - First Definitive - MTW	79.8%	75.8%	79.8%	75.8%	-4.0%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	6.5	New	67.5	New	67.5	-	67.5	
4-19	Delayed Transfers of Care	4.3%	5.8%	4.0%	6.2%	2.2%	2.7%	3.5%	6.2%	
4-20	% TIA with high risk treated <24hrs	73.3%	81.3%	74.4%	70.5%	-3.8%	10.5%	60%	70.5%	
4-21	% spending 90% time on Stroke Ward	63.5%	82.4%	81.5%	81.7%	0.2%	1.7%	80%	81.7%	
4-22	Stroke:% to Stroke Unit <4hrs	38.6%	46.8%	38.8%	48.4%	9.6%	-6.6%	55.0%	48.4%	
4-23	Stroke: % scanned <1hr of arrival	48.9%	48.9%	43.5%	54.7%	11.1%	11.7%	43.0%	54.7%	
4-24	Stroke:% assessed by Cons <24hrs	62.2%	76.6%	72.4%	69.9%	-2.5%	-15.1%	85.0%	69.9%	
4-25	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-26	Patients not treated <28 days of cancellation	0	0	0	6	6	6	*0*	6	

CWT run one mth behind, YTD is Quarter to date* * Serious Incidents Rate is per 1,000 Occupied Beddays*

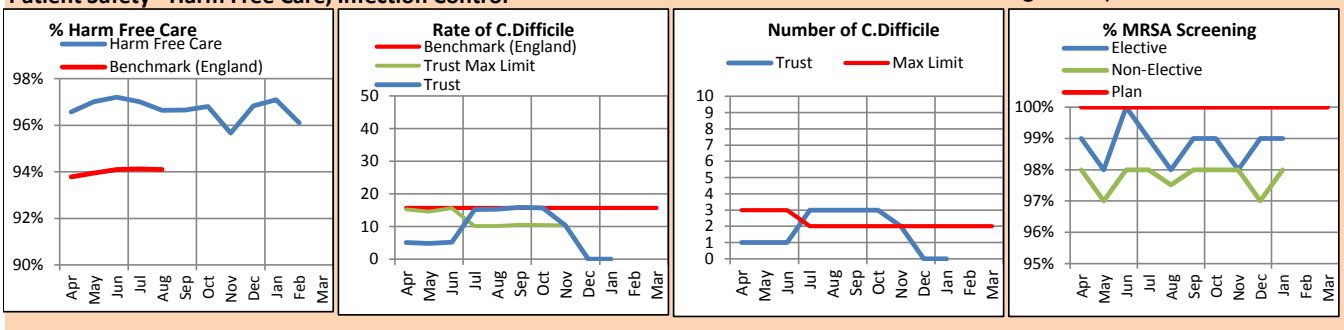
**** Contracted not worked includes Maternity /Long Term Sick* ***** Staff FFT is Quarterly therefore data is latest Quarter*

****** IP Friends and Family includes Inpatients and Day Cases* *******SHMI is within confidence limit*

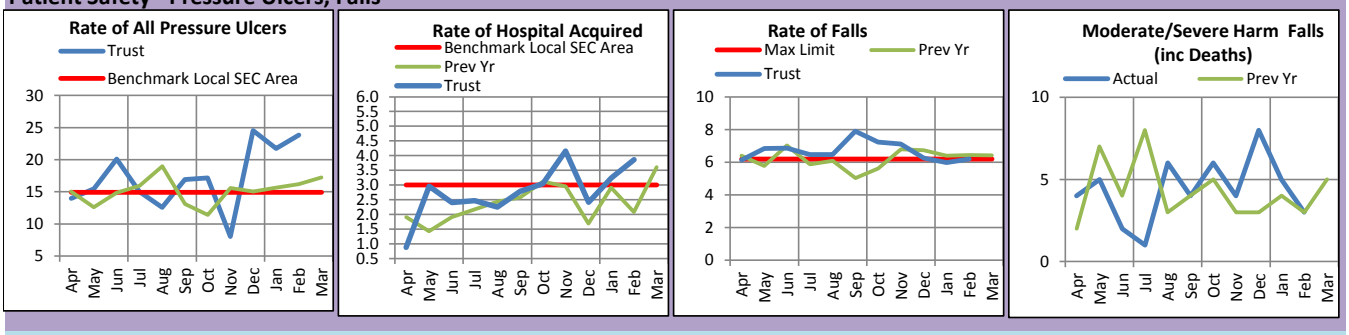
	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	33,549	32,952	363,750	364,489	0.2%	0.9%	400,587	399,790	
5-02	EBITDA	1,998	197	30,302	6,296	-79.2%	-68.5%	23,671	10,218	
5-03	Surplus (Deficit) against B/E Duty	(856)	(2,792)	(1,710)	(24,762)			(12,132)	(23,515)	
5-04	CIP Savings	1,675	1,438	21,563	18,965	-12.1%	-4.1%	21,496	20,752	
5-05	Cash Balance	20,371	8,507	20,371	8,507	-58.2%	132%	2,127	1,000	
5-06	Capital Expenditure	542	1,297	5,533	11,194	102.3%	-36.2%	*18,963*	14,823	
5-07	Establishment (Budget WTE)	5,493.2	5,702.5	5,493.2	5,702.5	3.8%	0.0%			
5-08	Contracted WTE	4,981.5	5,148.3	4,981.5	5,148.3	3.3%	-4.9%			
5-09	***Contracted not worked WTE	(95.3)	(99.9)	0.0	(99.9)					
5-10	Locum Staff (WTE)	20.1	21.1	20.1	21.1	4.8%				
5-11	Bank Staff (WTE)	279.1	331.4	279.1	331.4	18.7%				
5-12	Agency Staff (WTE)	211.8	276.0	211.8	276.0	30.3%				
5-13	Overtime (WTE)	72.4	45.8	72.4	45.8	-36.8%				
5-14	Worked Staff WTE	5,494.9	5,713.6	5,494.9	5,713.6	4.0%	0.2%			
5-15	Vacancies WTE	511.7	554.2	511.7	554.2	8.3%				
5-16	Vacancy %	9.3%	9.7%	9.3%	9.7%	4.3%				
5-17	Nurse Agency Spend	(595)	(990)	(5,035)	(9,379)	86.3%				
5-18	Medical Locum & Agency Spend	(849)	(939)	(9,174)	(11,297)	23.1%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	8.6%	10.4%		10.0%	1.9%	-0.1%	*10.5%*	10.0%	8.4%
5-21	Sickness Absence	4.2%	No data		3.9%			*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	84.7%	90.4%		90.4%	5.7%	5.4%	85.0%	85.0%	
5-23	Appraisal Completeness	80.6%	80.5%		80.5%	-0.2%	-9.5%	90.0%	80.5%	
5-24	Overall Safe staffing fill rate	101.5%	#DIV/0!	101.0%	101.6%	#DIV/0!		93.5%	101.6%	
5-25	****Staff FFT % recommended work	New	56.9%	New	57.6%		-1.1%	58.0%	57.6%	62.9%
5-26	***Staff Friends & Family -Number Responses	New	253	New	253					
5-27	*****IP Resp Rate Recmd to Friends & Family	New	13.6%	New	25.1%		-4.9%	30.0%	25.1%	25.1%
5-28	A&E Resp Rate Recmd to Friends & Family	New	6.0%	New	13.0%		-7.0%	20.0%	13.0%	13.1%
5-29	Mat Resp Rate Recmd to Friends & Family	15.4%	13.5%	18.7%	20.3%	1.6%	5.3%	15.0%	20.3%	23.4%

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

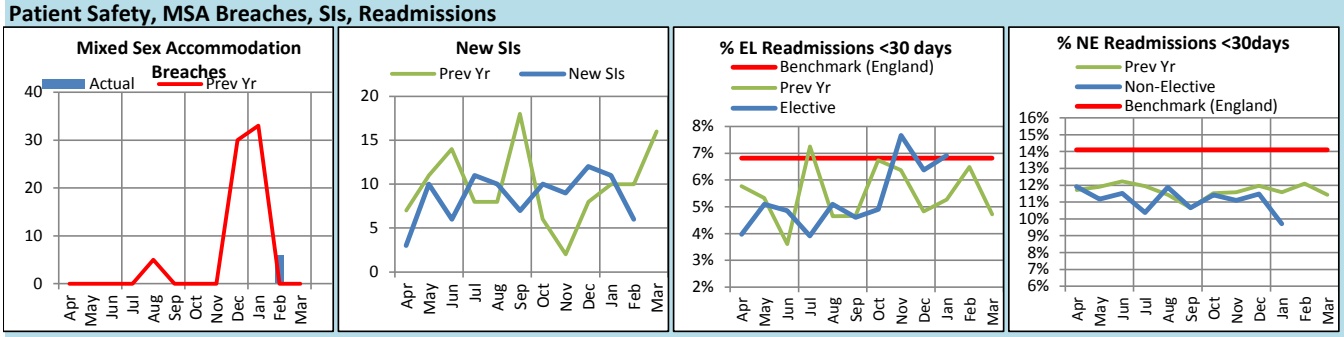
Patient Safety - Harm Free Care, Infection Control



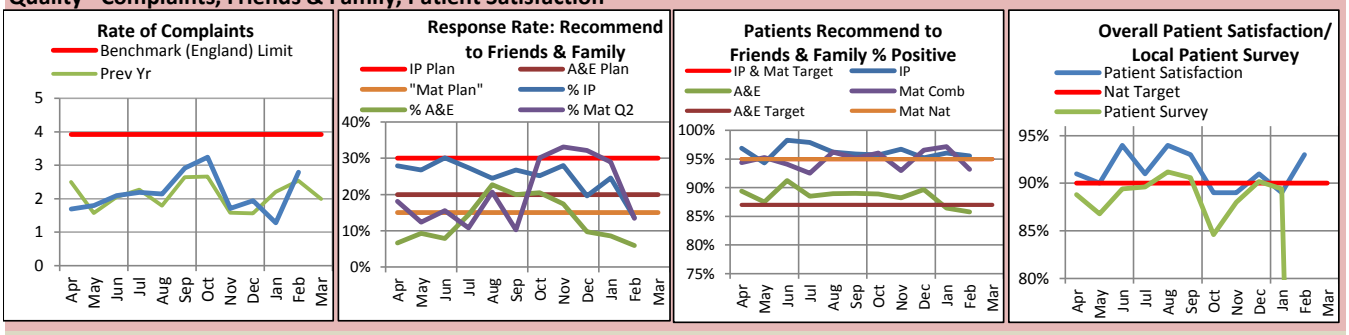
Patient Safety - Pressure Ulcers, Falls



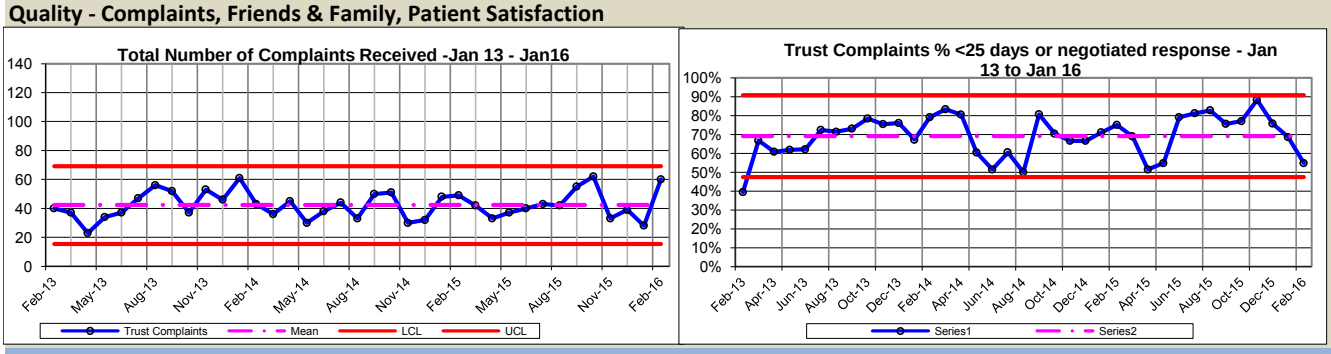
Patient Safety, MSA Breaches, SIs, Readmissions



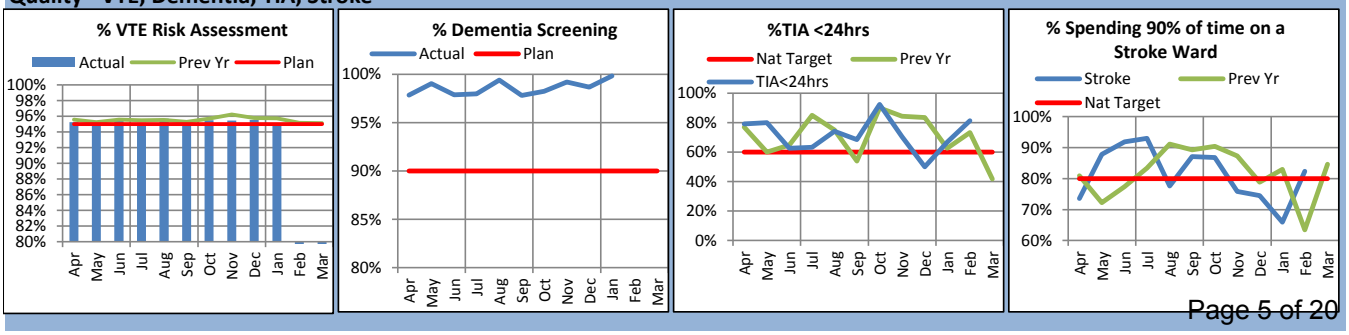
Quality - Complaints, Friends & Family, Patient Satisfaction



Quality - Complaints, Friends & Family, Patient Satisfaction

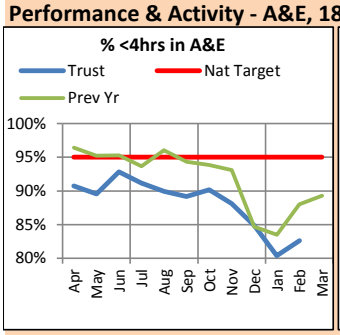


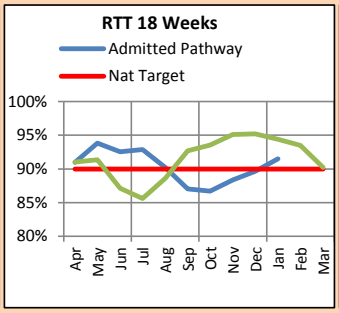
Quality - VTE, Dementia, TIA, Stroke

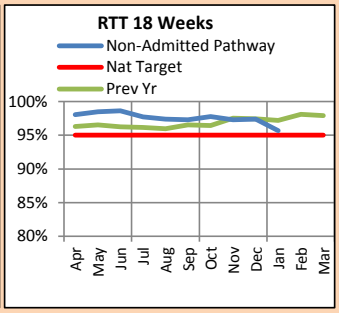


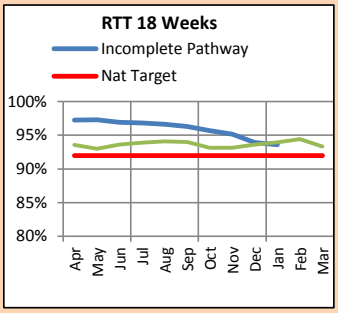
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

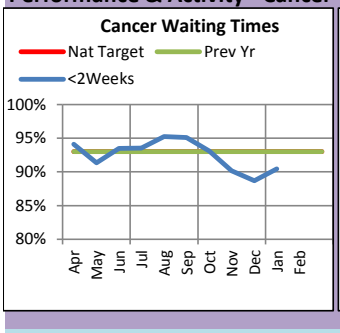


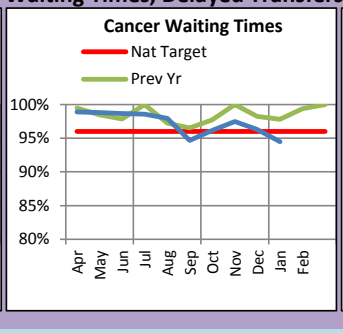


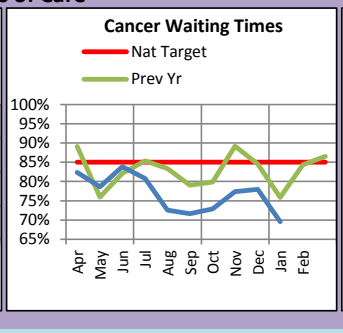


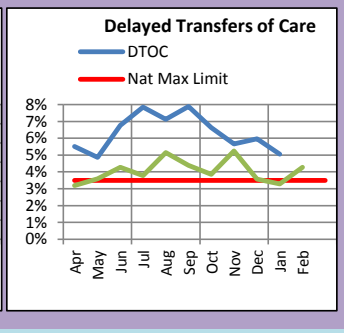


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

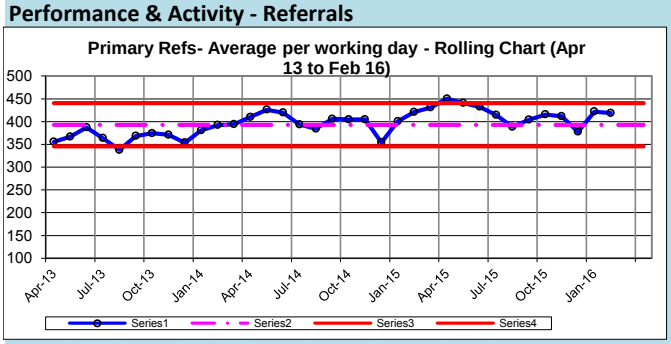


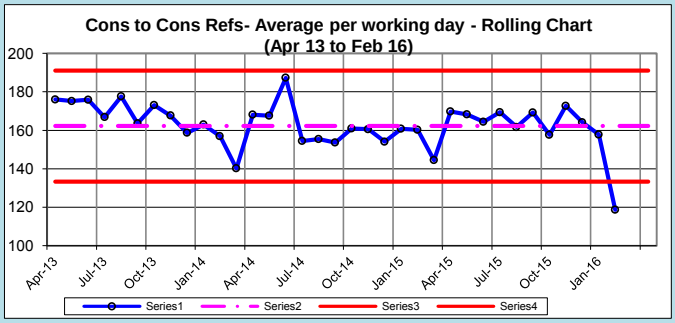




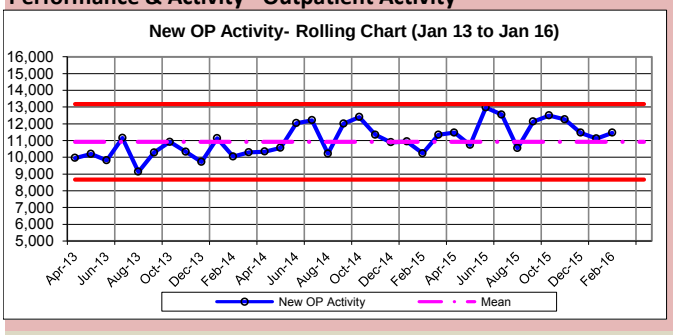


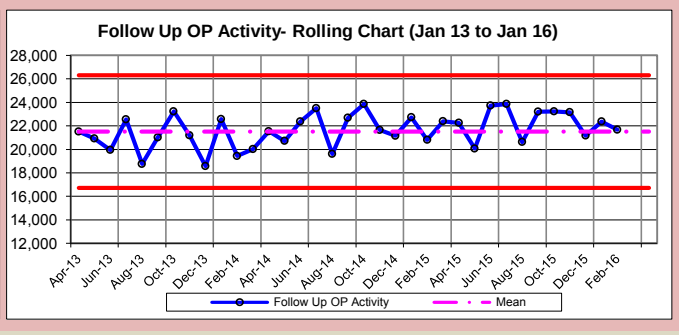
Performance & Activity - Referrals



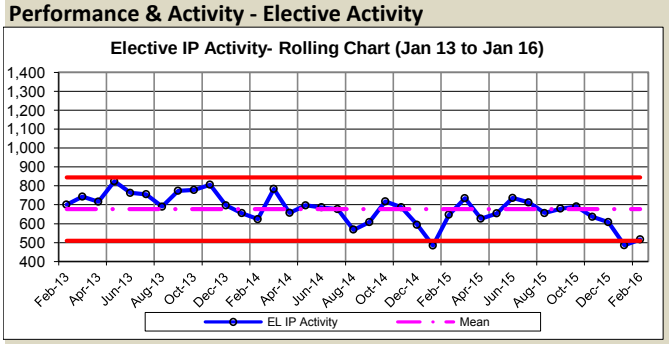


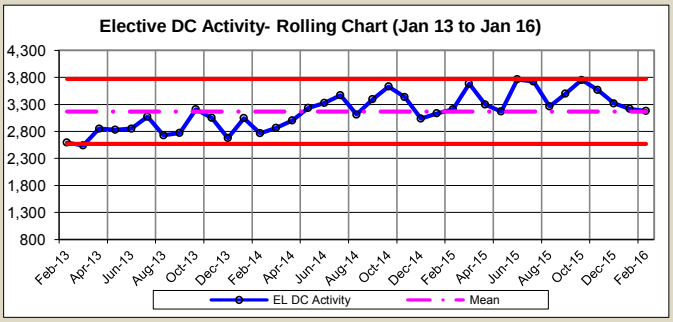
Performance & Activity - Outpatient Activity



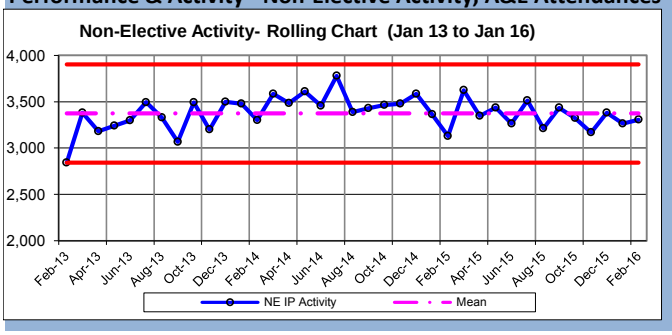


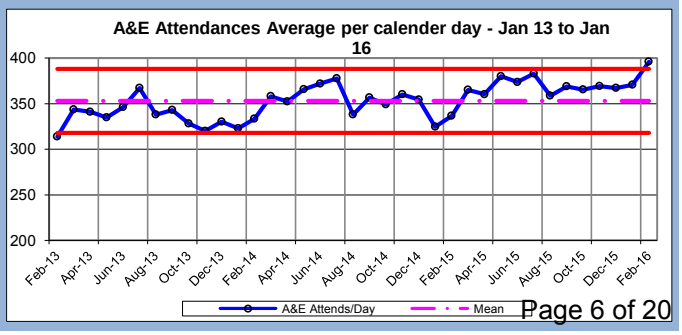
Performance & Activity - Elective Activity





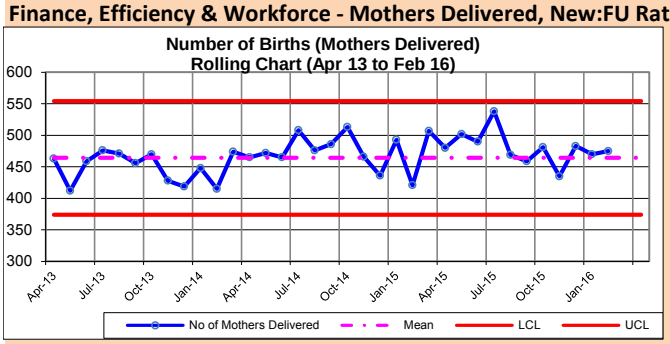
Performance & Activity - Non-Elective Activity, A&E Attendances

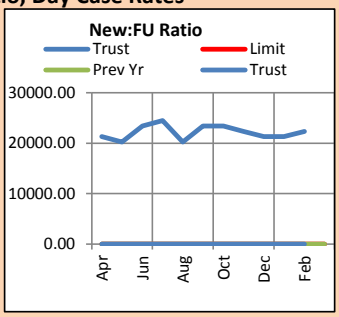


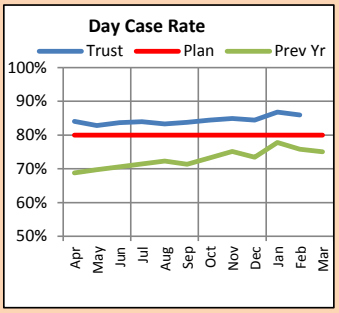


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

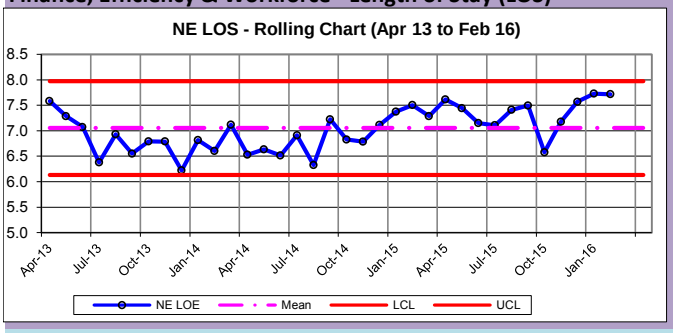
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

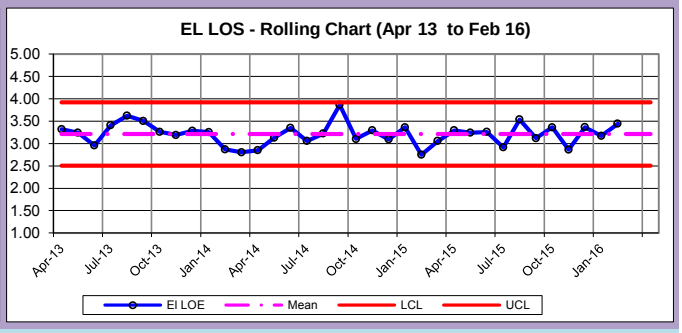




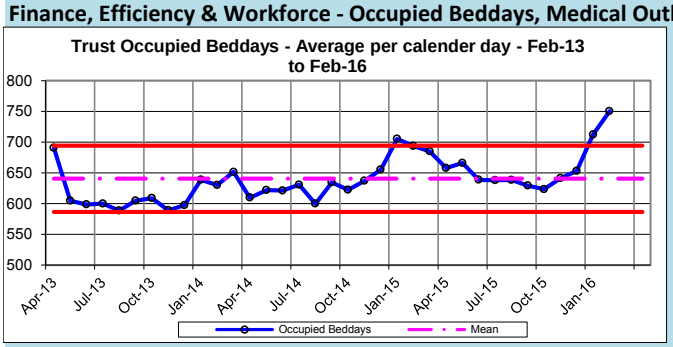


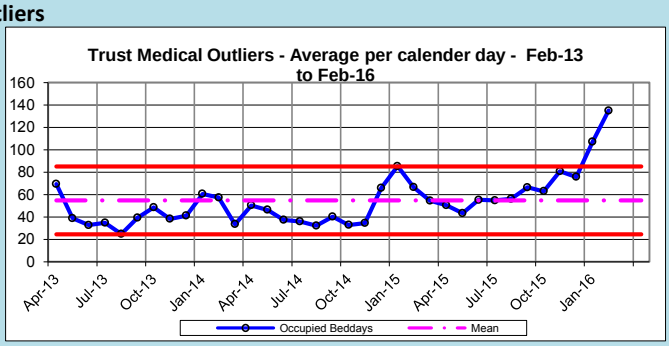
Finance, Efficiency & Workforce - Length of Stay (LOS)



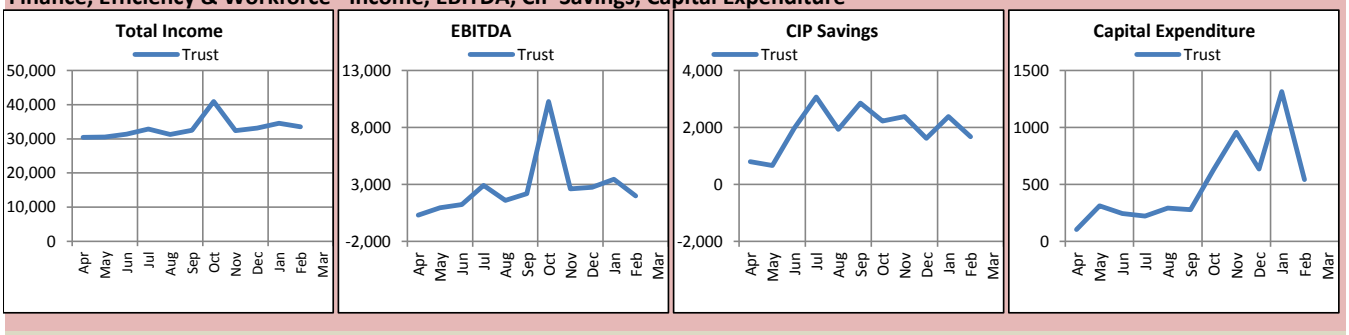


Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

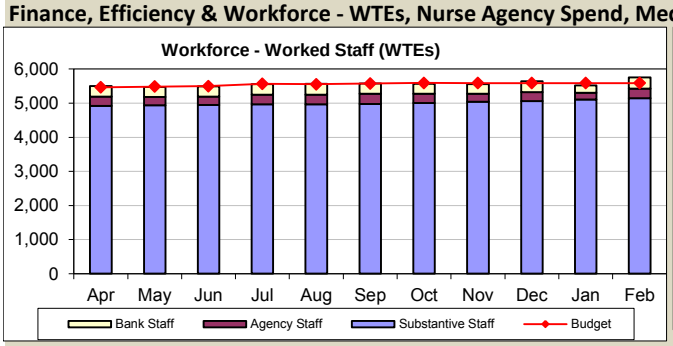


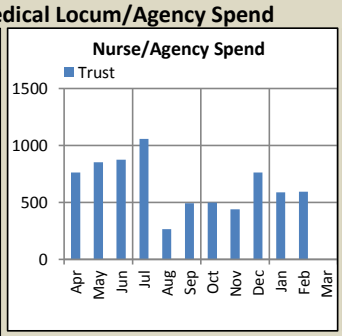


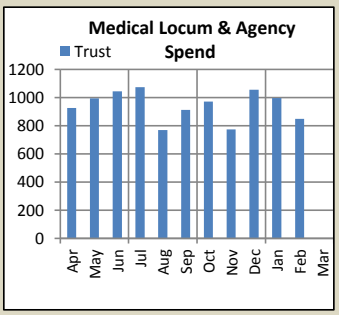
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure



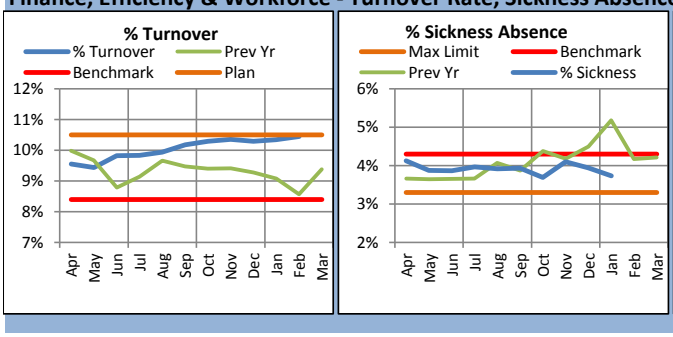
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

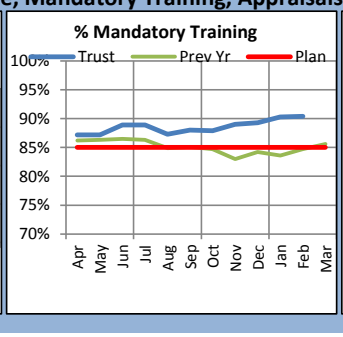


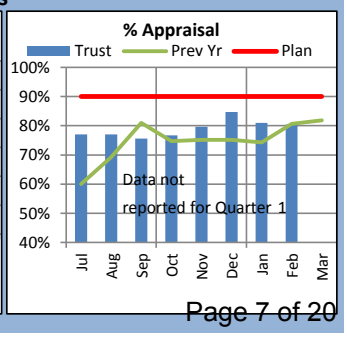




Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals







Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

Review of latest financial performance **Director of Finance**

Summary / Key points

- The Trust had an adverse variance against plan at the end of February 2016 of £11.99m, an increase of £2.09m in the month.
- The Trust's net deficit to date (including technical adjustments) is £24.76m against the planned deficit of £12.77m. In the month the Trust operated at a deficit of £2.79m against a plan of £0.7m deficit for February.
- There remain a number of significant risks to the Trust's year end position. The risks are:
  - The Trust's ability to deliver its elective workload to planned levels and the recent trend of lower levels of SLA income performance coupled with high occupied bed days, lengths of stay and delayed transfers of care;
  - The impact of staffing costs over plan, including delivery of the plans in place to reduce agency reliance and recruit substantive posts;
  - The CCG's ability to provide the finance requested and included in the Trust's forecast to support escalation capacity, winter pressure plans, CQC action plan investments (e.g. in critical care outreach) & A&E paediatric doctors;
  - The ability for the Trust to identify further technical adjustments to help mitigate the impact of the worsening trend of elective income and nurse agency costs.
- In Feb the Trust operated with an EBITDA deficit of £0.20m which was £1.20m adverse to plan.
- The Trust held £8.5m of cash at the end of January, an increase of £4.4m from the end of January. The Trust received notification during the month of DH approval of the application for £3.5m capital finance relating to the TWH ward project. This has been approved as PDC capital funding and will be drawn down in March. The Trust had an adverse variance against plan at the end of February 2016 of £11.99m, an increase of £2.09m in the month.
- The Trust's net deficit to date (including technical adjustments) is £24.76m against the planned deficit of £12.77m. In the month the Trust operated at a deficit of £2.79m against a plan of £0.7m deficit for February.
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  - The impact of staffing costs over plan, including delivery of the plans in place to reduce agency reliance and recruit substantive posts;
  - The CCG's ability to provide the finance requested and included in the Trust's forecast to support escalation capacity, winter pressure plans, CQC action plan investments (e.g. in critical care outreach) & A&E paediatric doctors;
  - The ability for the Trust to identify further technical adjustments to help mitigate the impact of the worsening trend of elective income and nurse agency costs.
- In Feb the Trust operated with an EBITDA deficit of £0.20m which was £1.20m adverse to plan.

The Trust held £8.5m of cash at the end of January, an increase of £4.4m from the end of January. The Trust received notification during the month of DH approval of the application for £3.5m capital finance relating to the TWH ward project. This has been approved as PDC capital funding and will be drawn down in March.

Which Committees have reviewed the information prior to Board submission?

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Briefing paper – Finance Committee

M11 Financial Performance overview

1. Overview of the Financial Position at M11 2015/16

1.1. This written summary provides an overview of the financial position at M11 of 2015/16. It should be read alongside the detailed finance pack, which has also been circulated to committee members.

1.2. Under the TDA Accountability Framework the Trust is flagged as Red due to its reported financial position at month 11. The Finance pack shows for month 11 the Trust moved out adversely by £2.09m against its in-month deficit plan of £0.7m resulting in a year to date deficit of £24.76m against a planned deficit of £12.77m. This is an adverse year to date variance of £11.99m. These figures include the full utilisation of reserves available for the first eleven months of 2015/16.

Income

1.3. Total income for the year to date is £364.49m against a budget of £361.11m. Income for the month is £32.95m compared to the £33.58m plan for the month.

1.4. The income headlines are outlined below:

- Total income is £3.40m favourable to plan year to date.
- All applicable contractual deductions and penalties have been included and a provision has been made for challenges. A total of £6.33m provisions/deductions and £5.37m threshold adjustments are included in the year to date position with £6.91m provisions/deductions and another £5.97m threshold adjustments in the forecast outturn.
- A&E attendance activity remains higher than in the corresponding period of last year.
- The A&E Conversion rate has decreased to 25.90% in month 11 compared to the 26.73% experienced in month 10.
- Re-chargeable on High cost drugs and devices are favourable in the month by £0.78m, and year to date £6.32m but these are pass through costs charged back to CCGs so there is a corresponding over-spend in the non-pay budgets.

1.5. There was an increase in Elective inpatient and day case activity compared to last month's level (£3.80m in month 11 compared to £2.60m in month 10) with a year to date (YTD) under performance of £4.27m, including dependency on outsourced activity.

1.6. The increase from last month's level is largely due to an adjustment for a CCG challenge relating to the application of best practice tariff rules (£0.9m) which was put through in month 10. Elective cancellations remain high as a result of the high number of non-elective patients occupying beds.

1.7. The financial impact of elective cancellations in the month is c£1.2m. This is mainly due to bed unavailability (381 in February vs 418 in January and 1789 YTD-all cancellations), while the reportable cancellations decreased from 1% in January to 0.7% in February. The impact of cancellations was most notable in T&O.

1.8. In month 11 A&E attendances remained relatively flat compared to the last 6 months' level and the conversion rate decreased from 26.73% to 25.94%. To date A&E attendances are slightly above planned income levels (£0.13m) but this is higher than last year's level of income by 27.40%.

1.9. The Trust continues to experience an increase in the acuity of patients presenting in A&E and ultimately LOS when such patients are admitted. Overall, the level of occupied bed/day remains high and has increased further in month 11 resulting in increased usage of escalation capacity to manage flows in A&E.

1.10. Even though NEL activity has reduced YTD compared to the corresponding period of last financial year, NEL admissions have increased by 5.6% in February (compared to the corresponding period of last financial year), the richer and more acute case-mix experienced throughout the current financial year has resulted in longer lengths of stay and an increase in the occupied bed days (OBD). During the same comparator period between years (April to February) delayed transfers of care (DTOCs) have increased to their highest ever levels (February comparison year on year 5.8% to 4.3%, some previous months have been over 7%). The increase in OBDs has generated a 7.1% increase (compared to the same period YTD of last financial year) in income from excess bed days which are only paid beyond the relevant HRG “trim point”. NEL admissions are lower than planned in the month albeit slightly, mitigated by the increase in partially completed spells which are yet to be included in the position (Estimated at c£0.3m).

1.11. From April 2015 to February 2016, the Trust reported a total of 185,410 non elective occupied bed days compared to the 177,214 bed days used in the corresponding period of last year, representing a 4.62% increase. Our high bed utilisation rate coupled with our inability to discharge patients quicker is increasing the level of OBDs. Between month 10 and month 11 the daily bed occupancy rate has increased by 21 beds per day resulting in a total bed utilisation of 18,708 in February [29 working days] (16,505 in corresponding period of last financial year albeit we had 28 working days) compared to the 19,335 bed days utilised in January [31 working days].

1.12. The increase in acuity (evidenced by an increased level of income per spell) and length of stay is reducing the throughput in non-elective activity, which is further reflected in an increase in medical outliers (which is currently at its highest ever level – 49.48% up on last year’s level). This high bed occupancy and LOS levels is forcing the Trust to increasingly rely on escalation capacity, resulting in the designation of Foster Clark as an escalation ward and Whatman ward remaining open throughout February at its increased capacity of 28 beds during the course of the month.

1.13. Outpatient activity (excluding diagnostics) is £4.59m in month 11 compared to £4.6m in the previous month. Year on year, the income from outpatient activity is 11.05% higher the corresponding period of the previous financial year but is still lower than planned levels (£0.68m YTD).

1.14. Readmissions, A&E waits, RTT and other contractual penalties (relating only to incomplete pathways) increased from a YTD level of £3.5m in January to a YTD level of £3.9m in February. The Readmissions, RTT and A&E penalties are calculated from Month 11 data whilst the other contractual penalties (e.g. First to Follow up OP ratios, Data quality queries) are estimates.

1.15. An 85% achievement rate for CQUINs continues to be assumed in the income position.

1.16. Non recurrent transitional support of £3.32m year to date for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

Outsourcing

1.17. The value of income related to outsourced activity remained at last month's level of £0.31m in February with a year to date total of £2.99m. For outsourced activity the Trust pays costs that remove any contribution that it would earn from undertaking the activity in-house. Over 80% of the income for outsourced activity for the year to date relates to orthopaedic cases where there may be potential to undertake this work internally by increasing actual or productive in house capacity.

Expenditure

1.18. Operating costs are £16.6m adverse for the year to date against a planned budget of £341.6m, including available reserves. Pay was over plan by £1.57m in February generating a year to date adverse variance of £11.61m.

1.19. Non pay (including reserves of £1.5m year to date) underspent by £0.22m in February and is £4.99m overspent year to date.

1.20. Substantive staffing is underspent for the year to date by £0.7m made up of underspending on medical posts (£1.04m), scientific posts (£0.38m) and nursing posts (£0.13m). In the month substantive pay costs overspent by £0.47m.

1.21. The year to date major overspends on agency usage are in Nursing (£6.28m), Medical agency (£2.22m), Scientific/Therapeutic agency (£1.15m) and Admin & Clerical (£1.12m). Nurse agency spend has risen from last month's level of spend (£827k) by £163k and reflects a full month effect of an additional escalation ward opening. Total agency costs are up on last month's levels by £315k overall (£1,427k compared to £1,742k). Total bank costs (including medical locums) are over planned levels by £0.13m in the month which gives a year to date overspend of £1.18m. The bulk of the adverse movement was on medical locums (£88k) which are currently £1.32m overspent to date.

1.22. The trajectory submitted to the TDA set out a reduction in agency costs from September (for trained nursing) of £0.5m through to the end of March with an overall reduction, including additional permanent staffing, of £0.3m. In February the qualified agency nursing increased to £953k from £806k in January and was largely linked to the increase in escalated beds. This was £563k greater than the February trajectory target which was set at £390k. The trajectory submitted to the TDA assumed that the total qualified agency nursing spend would be 6.7% by February but the Trust performance is actually 8.1% worse at 14.8%. Escalation pressures have contributed to the Trust not meeting the planned trajectory reduction.

1.23. Significant non pay overspends for the year to date are:

- Drugs and medical gases £7.02m adverse (offset in the position by the over performance in HCD income to date of £5.9m)
- Clinical Supplies is £1.87m adverse to plan – this includes cardiology devices (e.g. ICDs) that are charged back to the CCGs. The spend levels have dropped and are £123k lower than last month's levels. This reduction will in part be due to the reduced elective activity levels.
- Purchase of Healthcare from non NHS is adverse to plan by £3.43m reflecting outsourced usage to date. This is largely offset by the corresponding activity based income (£2.99m), though this provides no net contribution to the Trust financial position.

1.24. Significant non pay underspends for the year to date are:

- Other non-pay costs are underspent by £4.96m to date. Included in other non-pay also includes costs relating to the corporate manslaughter legal case which are estimated at £0.55m.
- Premises costs are £1.74m underspend to date which is linked to an expected rates rebate of £1.6m for earlier years for the Tunbridge Wells Hospital. This rebate has been included in the February position.

1.25. EBITDA is a £6.3m surplus year to date and is now adverse to plan by £13.7m.

1.26. The financing costs including those related to the PFI and deprecation total £32.1m year to date which is underspent against the plan by £1.5m. The plan was agreed prior to the finalisation of the revaluation in year-end accounts, which reduced planned levels of deprecation. In addition, the in-year capital plan reprioritisation and "capping" to provide funding for the new TWH ward development has slowed down originally planned spend, and diverted it from shorter life, higher depreciating assets such as medical and IT equipment into build assets.

Forecast Outturn & Risks on delivery

1.27. The forecast deficit for 2015/16 is £23.5m. The year to date performance against the trajectory submitted to the TDA is adverse by £99k. Appendix A includes a bridge from the original 2015/16 plan to the forecast deficit for this financial year.

Balance Sheet & Capital

1.28. Cash balances of £8.5m were held at the end of February (£4.1m at the end of January). In February the Trust received £4m over performance payment from WKCCG and £3m quarter 4's PFI support from NHS England. In March the cash flow forecasts receipt of the remaining £6.4m from the Interim Revenue Support Facility and £3.7m in respect to capital PDC. The forecast also assumes no further receipt of over performance for 2015/16.

1.29. Total debtors are £30.6m at the end of February, £8.8m lower than the reported January figure. Debt over 90 days has decreased by £2.9m to £8m at the end of February. Debtors in excess of a £1m are;

- WKCCG £6.1m
- EK Hospitals FT £2.7m
- Medway FT £1.2m

90 day invoiced debt for private healthcare is currently £0.2m (£1.7m in total for all invoiced debt) with other non NHS invoiced debt over 90 days old totalling £0.7m (£2m in total).

1.30. Total creditors are £54.7m. Included within creditors is £13.8m deferred income of which £5.7m relates to 5 SLA advances and a further £4m from WK CCG. Against the 95% target for payments made within 30 days the Trust achieved in value 78.1% in February for Trade creditors (81.3% in March 2015) and 79.5% in February for NHS creditors (66.6% in March 2015).

1.31. The pressure on the Trust's outturn position means that it is necessary for the Trust to manage its cash through tight controls over its working capital. This may involve further actions such as delaying the PFI unitary payment from March to April. Tax, NI and Pension would may also be deferred from March to April along with further restricting supplier payments.

1.32. Capital expenditure to month 11, including donated assets, was £11.2m which is an under-spend of £6.3m against the Trust's original plan of £17.5m for the same period. The forecast

net outturn of c.£15m is £5.0m lower than the original plan, which is mainly accounted for by the agreement to reduce its loan request by £3m, and the decision not to proceed at this stage with the disposal of the Hillcroft residence (£0.9m, matched by reduction in spend). The Trust is anticipating spend in the final month of the year will bring it up to its forecast outturn as the new ward is completed and ICT and equipment is delivered.

1.33. The Trust previously revised its Capital Plan to the TDA in line with its Finance Improvement response, reducing its request for capital loans by £3m to £3.5m.

1.34. The Trust has now received approval from the DH in respect of £3.5m confirmed as Capital PDC which the Trust is forecasting to receive in March.

2. CIP Delivery

2.1. The month 11 position shows a total CIP delivery (including full year effects) of £18.9m against the target that was included in the TDA plan of £19.7m, so under-performing by £0.8m to date.

2.2. The schemes identified are forecast to deliver £20.6m by year end which is £0.1m less than the forecast reported at month 10 and £0.9m below the plan of £21.5m.

2.3. Against the year to date total CIP expectation of £19.7m, under performance on Length of Stay (£1.11m), Theatre Productivity (£0.42m), Back office (£0.89m), PPU (£0.22m), Drugs (£0.20m) and Medical Efficiency (£0.24m) are in part offset by overachievement in Nursing and STT Efficiency £0.85m, Procurement efficiencies £0.97m and Contract Management £0.57m.

3. Conclusion

3.1. February elective performance is lower than planned by £1.25m and reflects the high level of cancellations arising from bed capacity issues in meeting the non-elective inpatient demand. To date it has been necessary to outsource £2.99m of activity which has meant a loss of contribution. Outpatient activity is higher than last year, but is also behind the plan for this year, and there are issues in ensuring outpatient clinic capacity is fully utilised while referral rates rise and waiting lists are growing.

3.2. Non elective activity is lower than last year but total numbers of occupied bed days have increased, along with delayed transfers of care. Income per spell has increased, indicating higher complexity. The increase in acuity and length of stay is reducing the throughput in non-elective activity, which is further reflected in an increase in medical outliers and is adversely affecting bed capacity available for elective activity.

3.3. Staffing costs remain a key area of continued focus as part of the Integrated Recovery Plan and normal day to day control. Overall agency costs are up on last month's levels by £316k of which £163k relates to nurse agency primarily due to escalation pressures. Pay costs remain the most significant area of pressure on the Trusts' budgets, and is currently not being covered off by income at or above planned levels.

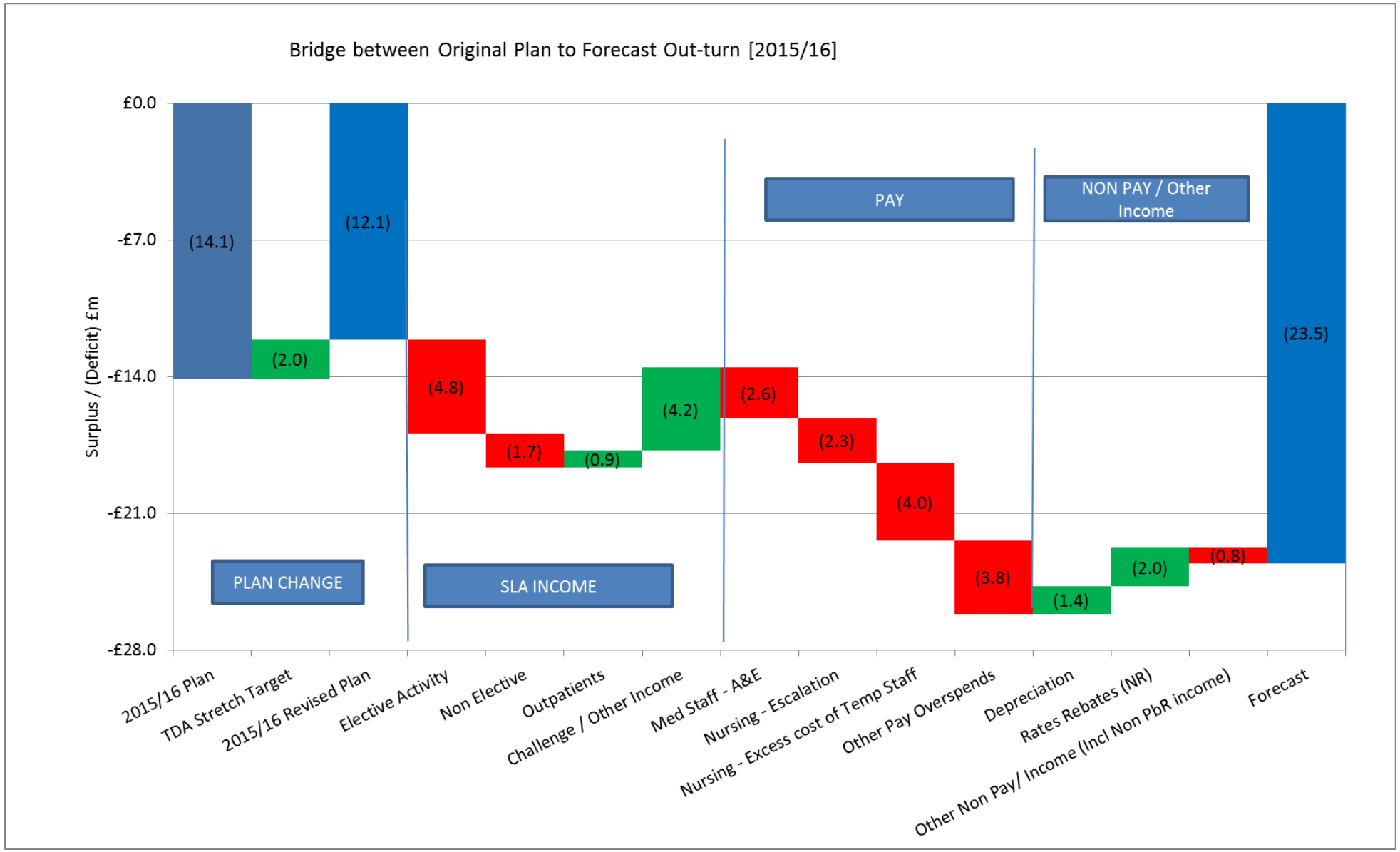
3.4. The Trust has put in place a number of additional recovery and control measures including:

- The issue of Directorate control totals and ongoing focus on agreeing recovery plans with clear trajectories which is monitored and discussed during bi-weekly meeting with the Directorates and Executive team.
- Publication of Service Line Reporting information to focus Directorates on opportunities for increased profitability and reduced costs

- Establishment of a Task and Finish Group to identify ways to maximise day case, elective and outpatient activity and income, and to reduce waiting lists, and to review activity that is being outsourced to ensure we increase net profitability.
- Staffing Controls – maintaining focus on reduction of agency costs, interim and consultancy usage. Review by Chief Nurse of nurse rotas exceeding the 1:8 ratio.
- Restricting further use of any unspent budgets & additional procurement controls applied on areas of discretionary spend, call-off orders and large orders.
- Focusing on liquidating NHS debt to give maximum flexibility on cash and exploring all options to stretch creditors to manage outturn pressures.

3.5. The Board are requested to note this report.

APPENDIX A


Bridge between Original Plan to Forecast Out-turn [2015/16]
Surplus / (Deficit) £m
£0.0
-£7.0
-£14.0
-£21.0
-£28.0
(14.1)
(2.0)
(12.1)
(4.8)
(1.7)
(0.9)
(4.2)
(2.6)
(2.3)
(4.0)
(3.8)
(1.4)
(2.0)
(0.8)
(23.5)
PLAN CHANGE
SLA INCOME
PAY
NON PAY / Other Income
2015/16 Plan
TDA Stretch Target
2015/16 Revised Plan
Elective Activity
Non Elective
Outpatients
Challenge / Other Income
Med Staff - A&E
Nursing - Escalation
Nursing - Excess cost of Temp Staff
Other Pay Overspends
Depreciation
Rates Rebates (NR)
Other Non Pay/ Income (Incl Non PbR income)
Forecast

Maidstone and Tunbridge Wells NHS Trust

Finance Pack

M11 - February 2015

February 2015

Maidstone and Tunbridge Wells NHS Trust

Contents

Key Performance Indicators as at Month 11 2015/16

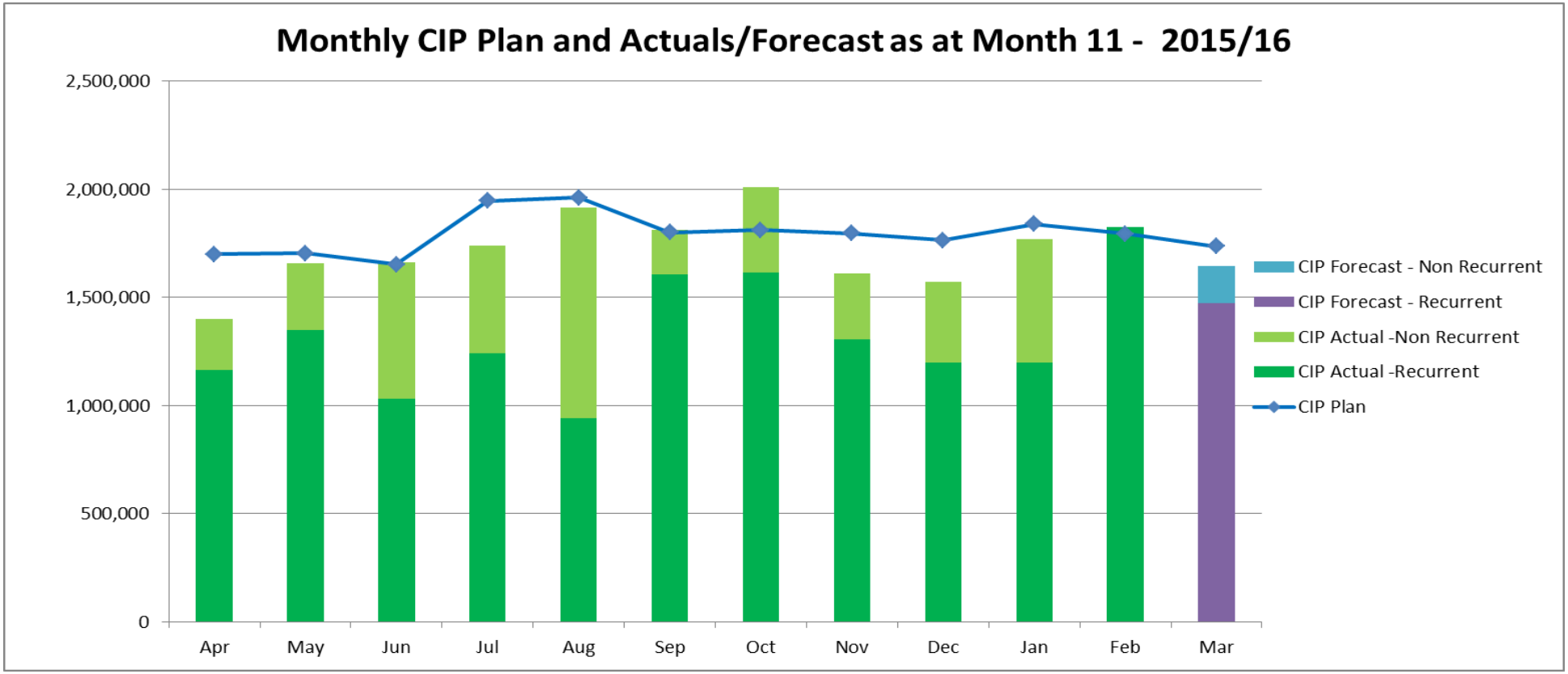
(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

Maidstone and Tunbridge Wells NHS Trust

Key Metrics (A) Accountability Framework	Current Month Metrics: Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	RAG Rating (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(12,132)	(23,515)	(11,383)	RED
1b) Year to Date, Actual compared to Plan	(12,771)	(24,762)	(11,991)	RED
Financial Efficiency				
2a) Actual Efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan				RED
- Total Efficiencies for Year to Date compared to Plan	16,410	15,743	(667)	
- Recurrent Efficiencies for Year to Date compared to Plan	16,410	11,079	(5,331)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	18,146	17,420	(726)	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	18,146	12,470	(5,676)	
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	14,839	14,839	0	GREEN
5) Permanent PDC accessed for liquidity purposes		10,500		RED
Trust Overall RAG Rating				RED
(B) Financial Sustainability Risk Ratings from M6 (Continuity of Services Risk Ratings for M3 to M5)				
Year to Date Rating	2.00	1.00	(1.00)	RED
Forecast Outturn Rating	2.00	1.00	(1.00)	RED

RAG STATUS	Red	Amber	Green
1a) Forecast Outturn, Compared to Plan	A deficit position or 20% worse than plan	A position between 5% - 20% worse than plan	Within 5% or better than plan
1b) Year to Date, Actual compared to Plan	20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or better than plan
Financial Efficiency			
2a) Actual Efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan	if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan	if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
Cash and Capital			
4) Forecast Year End Charge to Capital Resource Limit	either greater than plan or 20% lower than plan	between 10% - 20% lower than plan	Within 10% of plan
5) Permanent PDC accessed for liquidity purposes	PDC accessed	Not applicable	PDC not accessed
Trust Overall RAG Rating	If forecast deficit position or if three or more RED in other metrics	If one or two RED or three AMBER	No RED and less than two AMBER
(B) Financial Sustainability Risk Ratings from M6 (Continuity of Services Risk Ratings for M3 to M5)			
Year to Date Rating	If score is 2.5 or lower	Not applicable	Score of over 2.5
Forecast Outturn Rating	If score is 2.5 or lower	Not applicable	Score of over 2.5

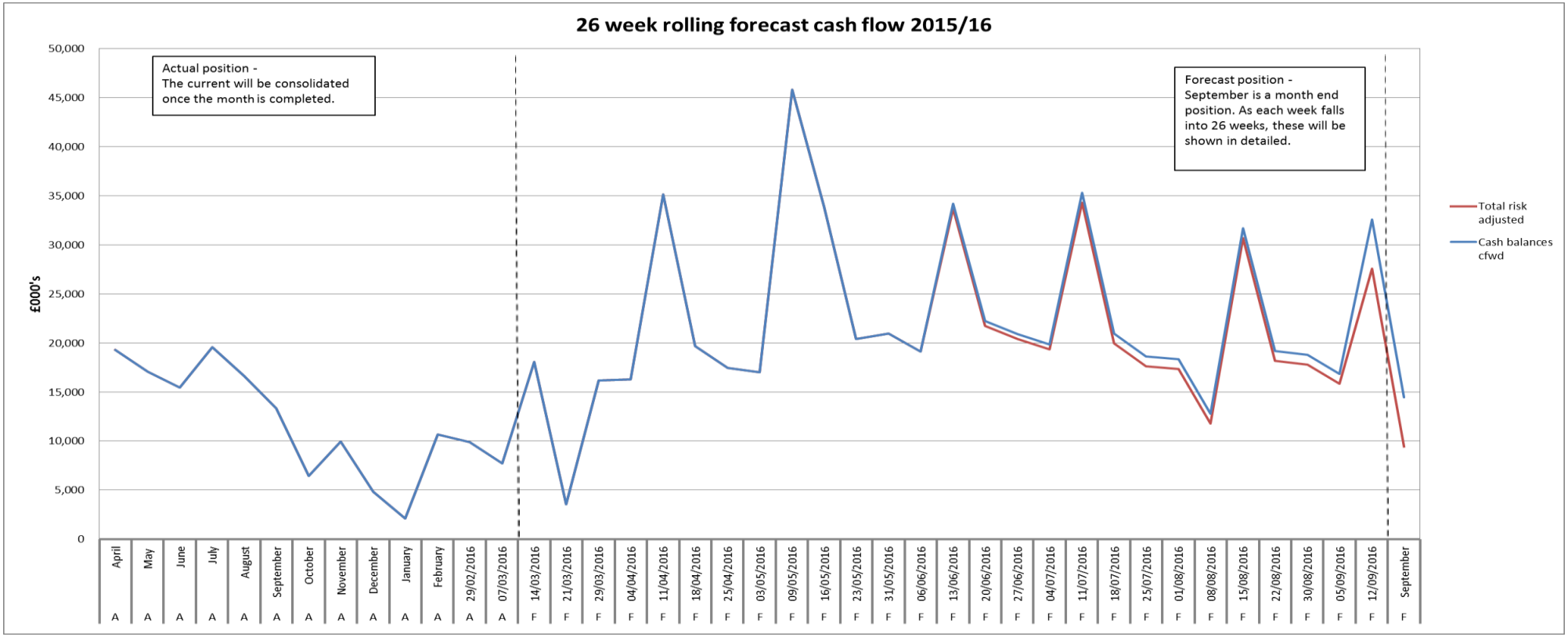
Maidstone and Tunbridge Wells NHS Trust



Recurrent v Non Recurrent	YTD
Recurrent Analysis	£000s
Recurrent	14,485
Non Recurrent	4,480
TOTAL	**18,965**

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of forecast cash balances up to w/c 5th September 2016, actuals at 4th March 2016



Week commencing	A April	A May	A June	A July	A August	A September	A October	A November	A December	A January	A February	A 29/02/2016	A 07/03/2016	F 14/03/2016	F 21/03/2016	F 29/03/2016	F 04/04/2016	F 11/04/2016	F 18/04/2016	F 25/04/2016	F 03/05/2016
Cash balances cfwd	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**6,434**	**9,970**	**4,838**	**2,094**	**10,663**	**9,902**	**7,703**	**18,068**	**3,574**	**16,189**	**16,302**	**35,108**	**19,673**	**17,421**	**17,014**
SLA overperformance 15/16 cfwd	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SLA overperformance 16/17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHD Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**6,434**	**9,970**	**4,838**	**2,094**	**10,663**	**9,902**	**7,703**	**18,068**	**3,574**	**16,189**	**16,302**	**35,108**	**19,673**	**17,421**	**17,014**

Week commencing	F 03/05/2016	F 09/05/2016	F 16/05/2016	F 23/05/2016	F 31/05/2016	F 06/06/2016	F 13/06/2016	F 20/06/2016	F 27/06/2016	F 04/07/2016	F 11/07/2016	F 18/07/2016	F 25/07/2016	F 01/08/2016	F 08/08/2016	F 15/08/2016	F 22/08/2016	F 30/08/2016	F 05/09/2016	F 12/09/2016	F September
Cash balances cfwd	**17,014**	**45,816**	**33,870**	**20,376**	**20,972**	**19,120**	**34,198**	**22,231**	**20,904**	**19,847**	**35,305**	**20,945**	**18,618**	**18,361**	**12,789**	**31,698**	**19,157**	**18,800**	**16,848**	**32,545**	**14,458**
SLA overperformance 15/16 cfwd	0	0	0	0	0	0	500	500	500	500	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
SLA overperformance 16/17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,000	4,000
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHD Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**17,014**	**45,816**	**33,870**	**20,376**	**20,972**	**19,120**	**33,698**	**21,731**	**20,404**	**19,347**	**34,305**	**19,945**	**17,618**	**17,361**	**11,789**	**30,698**	**18,157**	**17,800**	**15,848**	**27,545**	**9,458**

Maidstone and Tunbridge Wells NHS
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Trust Board meeting – March 2016

3-9	Integrated Performance Report for February 2016 – Amended Workforce commentary	Trust Secretary

The Workforce commentary that was circulated within the 'Story of the month' for February 2016 (pages 2 and 3 of Attachment 5) was incorrect.

Trust Board Members are therefore asked to disregard the workforce commentary within Attachment 5, and refer to the following, correct, commentary:

"During the month the Trust continued its recruitment performance and now employs 5,148 whole time equivalent substantive staff, as with the previous months this is an increase of 39 WTE compared with January 2016. This is the highest number of substantive staff employed by the Trust since reporting to the Board became the norm and represents a net increase of over 167 WTE against the same month last year. The month continued to see a net increase (47 WTE) in the numbers of substantive registered nurses and a marginal increase in clinical support workers. However, despite the recruitment success the dependence upon temporary staff remained higher than planned and further work is ongoing to ensure, in line with the TDA requirements, we reduce our dependence upon expensive agency and interim workers. However the use of bank staff increased in February to 331.4 WTE. A task and finish group has been established to focus on medical recruitment.

Sickness absence in the month was 4.1%, representing a marginal improvement on the same period last year (4.2%). Statutory and mandatory training compliance continues to increase with 90.4% of staff compliant with the core subjects. Actions are in place to improve compliance further."

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 15/03/16

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Discussion and scrutiny

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
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Trust Board meeting – March 2016

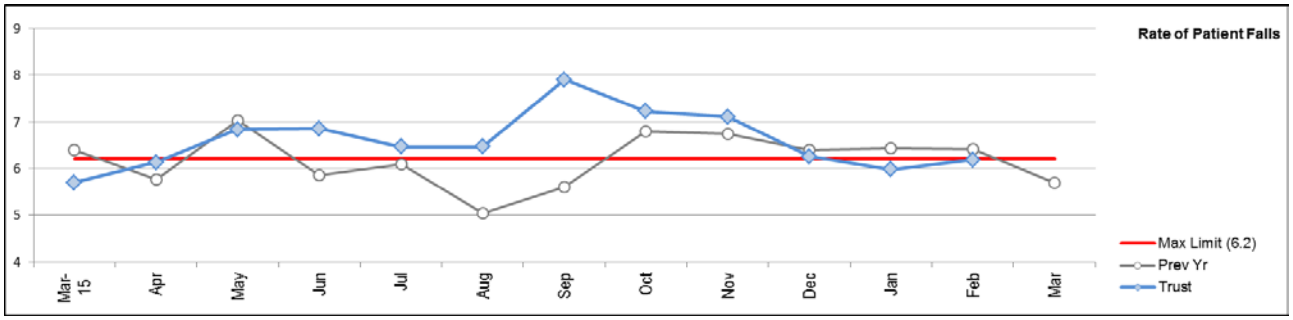
3-11 Supplementary Clinical Quality and Patient Safety Report Chief Nurse

This report provides information on actions being taken to improve the position with hospital acquired pressure ulcers and complaints and show the improvements being made with falls.
This report provides information on actions being taken to improve the position with hospital acquired pressure ulcers and complaints and show the improvements being made with falls.

The purpose of this report is to bring to the attention of the board any specific quality or patient safety issues that are either not covered within the integrated monthly performance report but require board oversight or are covered but require greater detail.

This report is intentionally brief, highlighting only those quality indicators / areas of work which require further explanation or acknowledgement. The Board is asked to note the content of this report and make any recommendations as necessary.

Falls

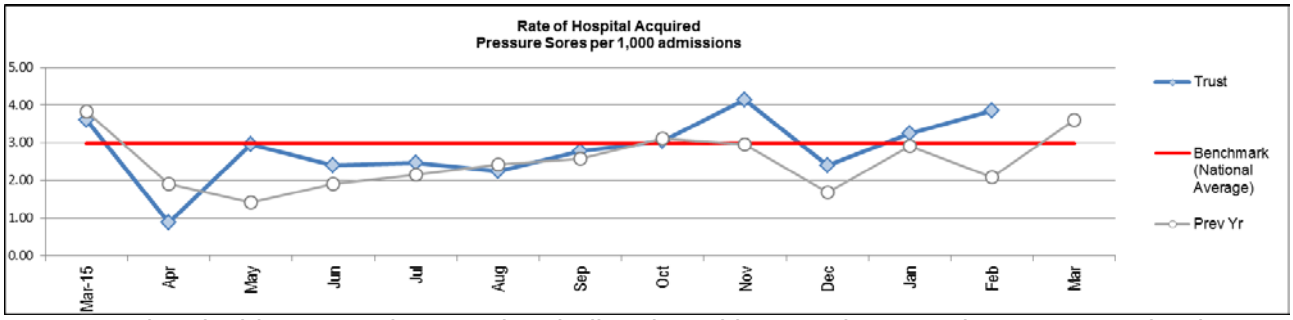


There were 133 patient falls reported for February but no Serious Incidents relating to falls were declared. This is the first month since October 2012 that the Trust has had no falls related serious incidents. This is very positive and supports the generally improving picture for falls rates over the 6 months.

Of the 133 falls reported, 104 resulted in No Harm, 26 resulted in Low Harm and 3 resulted in Moderate Harm. The rate of falls for February is 6.18 per 1,000 Occupied Bed days, with a threshold maximum of 6.20 per 1,000 Occupied Bed days

Despite high activity in the Trust, staff have engaged well with the continued falls prevention work including training and updating. In addition, there has been increased presence of falls prevention nurse on the wards to support and guide staff in practice, with the temporary secondment of another practitioner. Following a deep dive review in January by the Quality Committee the falls prevention group has revised its strategy drawing from emerging evidence from other Trusts on effecting sustained changes and improvements and shared these at the quality committee.

Pressure Ulcers



Pressure ulcer incidence continues to be challenging with a rate increase in January and February. So far incident reviews have not demonstrated any single change in practice.

A reinforcement of good practice, particularly relating to patients suffering incontinence, has been undertaken, supported by direct written communication from the Chief Nurse.

Ward Staff have been reminded to check where patients have been received from to ensure that all risk factors associated with trolleys, beds and transfers in taken into account when planning and delivering care.

The corporate nursing specialists are working closely to identify and manage key risks, including reminders for positional changes, use of the profiling function on the bedframes and use of pressure relieving cushions when sitting out of bed.

Education programmes are being reviewed, to ensure that all related subjects (such as moving & handling, falls prevention, dementia) include links to pressure damage prevention techniques and strategies.

A trust-wide pressure ulcer prevalence audit, including risk assessments, is being undertaken (15th & 16th March). This will help to further inform the education planning and assess the impact of the current and previous educational activity.

Discussions have commenced with Kent Community Health NHS Foundation Trust to establish a more robust approach to peer review of our practice. This is in addition to the collaborative work already being undertaken with the local Patient Safety Collaborative Group for pressure ulcer prevention.

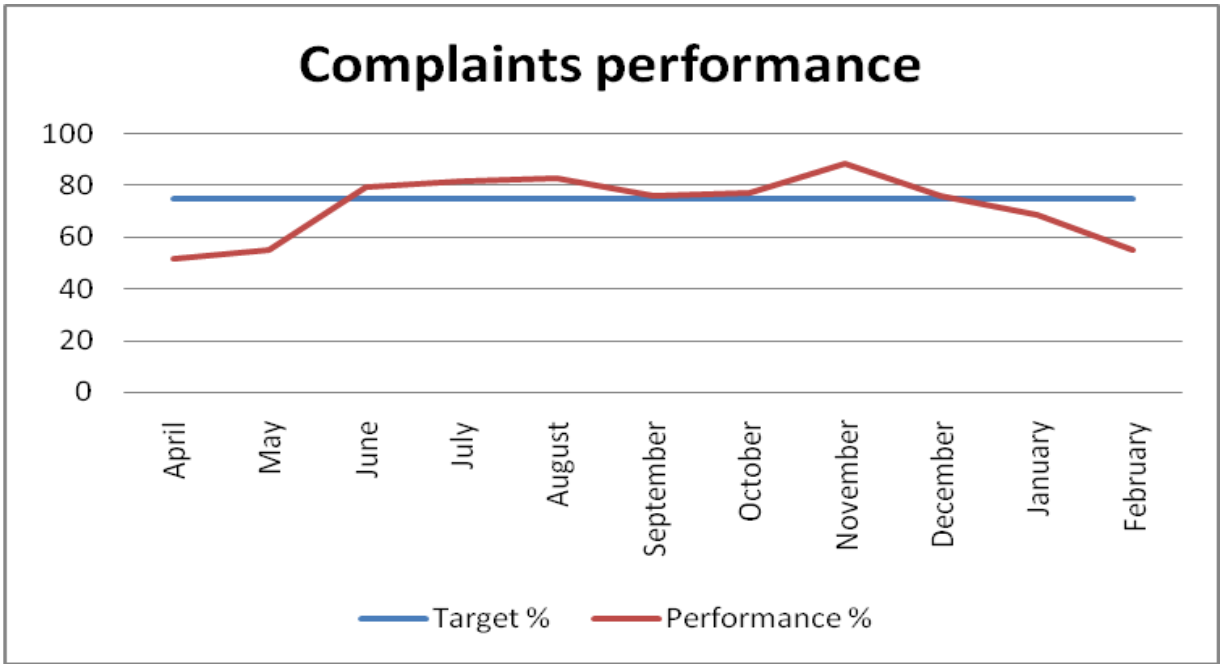
Complaints

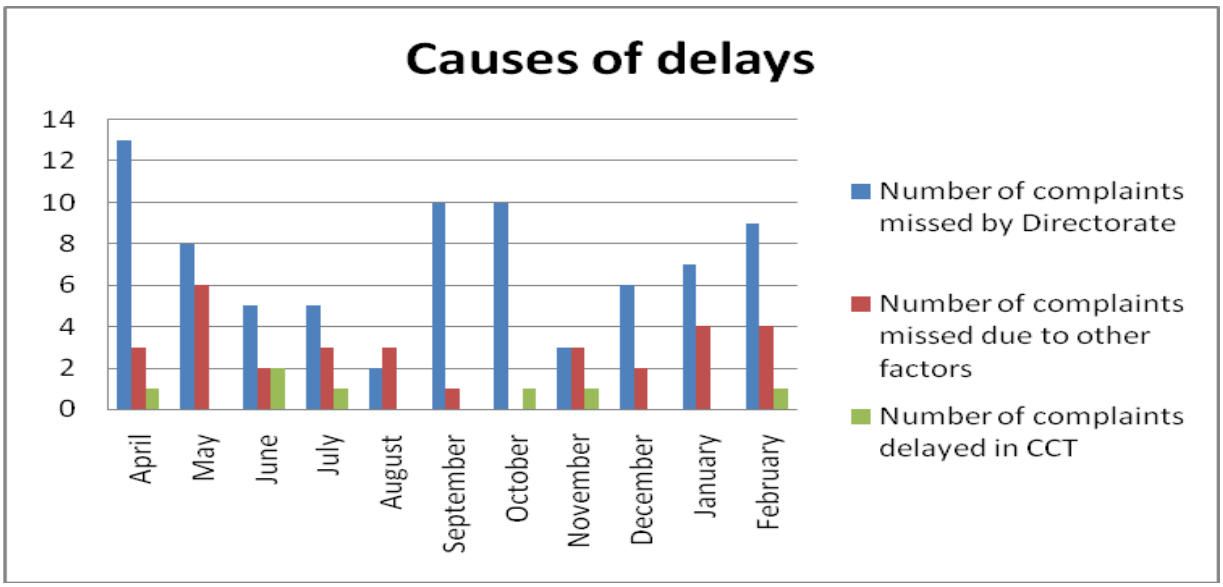
Following a period of sustained achievement of the Trust's performance target for responding to complaints, January and February 2016 has seen a decline.

This has been influenced by a number of factors including, the rise in complex complaints which are reliant on comments being provided to the Trust by other agencies, sustained levels of increased emergency activity and sickness in the corporate team.

Actions being taken to improve the position include the following:

- All open complaints are reviewed on a weekly basis to check progress, with reports to all directorates on the current status of their complaints.
- The Associate Director Quality Governance is meeting with the directorate leads where staff struggling to respond for requests for information to offer support and to agree a way to resolve the issues.
- Processes for highlighting cases due to breach have been reinforced, with early escalation to the Chief Nurse where there is outstanding information required.
- The central team continues to prioritise all cases on a daily basis to ensure response targets are met as much as possible without compromising the quality of the response.





Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
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3-12 The Learning from Mistakes League — Chief Nurse

NHS Trusts and Foundation Trusts have been publically ranked on their openness and transparency under a new "Learning from Mistakes League", which was launched by Monitor and the NHS Trust Development Authority (TDA) on 9th March.

Future publications are expected to be issued annually.

The league table has been drawn from the 2015 NHS staff survey and from the National Reporting and Learning System (NRLS). Providers have been given scores based on:

- The fairness and effectiveness of procedures for reporting errors, near misses and incidents;
- Staff confidence and security in reporting unsafe clinical practice
- The percentage of staff who feel able to contribute towards improvements at their Trust.

The data for 2015/16 shows that:

- 18 providers were judged to be "Outstanding"
- 102 were judged to be "Good"
- 78 were judged to have "Significant Concerns"
- 32 were judged to be "Poor"

The Trust has been ranked as "Good" (highlighted in yellow).

The full League is enclosed, for information. Other local Trusts are **emboldened**.

It is intended that NHS Improvement (which will bring together Monitor, the NHS TDA, the NRLS and the Patient Safety Team) will work with providers at the bottom of the league to assist them with improving their openness and transparency.

The National Patient Safety Director at NHS England has highlighted that the publication is a first attempt at a "Learning from Mistakes League", and has invited suggestions about how it might be improved in future'.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Trust	Category	Rank
Northumbria Healthcare NHS Foundation Trust	Outstanding	1
Oxleas NHS Foundation Trust	Outstanding	2
The Royal Marsden NHS Foundation Trust	Outstanding	3
Tees, Esk and Wear Valleys NHS Foundation Trust	Outstanding	4
Salisbury NHS Foundation Trust	Outstanding	5
Wrightington, Wigan and Leigh NHS Foundation Trust	Outstanding	6
Birmingham Children's Hospital NHS Foundation Trust	Outstanding	7
Tameside Hospital NHS Foundation Trust	Outstanding	8
Guy's and St Thomas' NHS Foundation Trust	Outstanding	9
Sussex Community NHS Trust	**Outstanding**	**10**
Liverpool Heart and Chest Hospital NHS Foundation Trust	Outstanding	11
Nottinghamshire Healthcare NHS Foundation Trust	Outstanding	12
Great Western Hospitals NHS Foundation Trust	Outstanding	13
Cambridgeshire Community Services NHS Trust	Outstanding	14
Bradford District Care NHS Foundation Trust	Outstanding	15
The Walton Centre NHS Foundation Trust	Outstanding	16
Surrey and Borders Partnership NHS Foundation Trust	Outstanding	17
Central London Community Healthcare NHS Trust	Outstanding	18
2Gether NHS Foundation Trust	Good	19
South Essex Partnership University NHS Foundation Trust	Good	20
The Christie NHS Foundation Trust	Good	21
Great Ormond Street Hospital for Children NHS Foundation Trust	Good	22
Lancashire Care NHS Foundation Trust	Good	23
Moorfields Eye Hospital NHS Foundation Trust	Good	24
Wirral Community NHS Trust	Good	25
Homerton University Hospital NHS Foundation Trust	Good	26
Calderstones Partnership NHS Foundation Trust	Good	27
Berkshire Healthcare NHS Foundation Trust	Good	28
Papworth Hospital NHS Foundation Trust	Good	29
Poole Hospital NHS Foundation Trust	Good	30
University Hospital Southampton NHS Foundation Trust	Good	31
Royal Surrey County Hospital NHS Foundation Trust	Good	32
Bridgewater Community Healthcare NHS Foundation Trust	Good	33
Bolton NHS Foundation Trust	Good	34
Hounslow And Richmond Community Healthcare NHS Trust	Good	35
Nottingham University Hospitals NHS Trust	Good	36
Worcestershire Health and Care NHS Trust	Good	37
Dudley And Walsall Mental Health Partnership NHS Trust	Good	38
Derbyshire Community Health Services NHS Foundation Trust	Good	39
The Clatterbridge Cancer Centre NHS Foundation Trust	Good	40
Frimley Health NHS Foundation Trust	Good	41
Central Manchester University Hospitals NHS Foundation Trust	Good	42
City Hospitals Sunderland NHS Foundation Trust	Good	43
Northumberland, Tyne and Wear NHS Foundation Trust	Good	44
Pennine Care NHS Foundation Trust	Good	45
Burton Hospitals NHS Foundation Trust	Good	46
Harrogate and District NHS Foundation Trust	Good	47
Hertfordshire Community NHS Trust	Good	48
Queen Victoria Hospital NHS Foundation Trust	**Good**	**49**
South Staffordshire and Shropshire Healthcare NHS FT	Good	50
Dartford And Gravesham NHS Trust	**Good**	**51**
Oxford Health NHS Foundation Trust	Good	52
Wye Valley NHS Trust	Good	53
Dorset Healthcare University NHS Foundation Trust	Good	54
Sheffield Children's NHS Foundation Trust	Good	55
Northamptonshire Healthcare NHS Foundation Trust	Good	56
South London and Maudsley NHS Foundation Trust	Good	57
Cumbria Partnership NHS Foundation Trust	Good	58
Rotherham Doncaster and South Humber NHS Foundation Trust	Good	59

Trust	Category	Rank
Shropshire Community Health NHS Trust	Good	60
Lincolnshire Community Health Services NHS Trust	Good	61
Greater Manchester West Mental Health NHS Foundation Trust	Good	62
Cornwall Partnership NHS Foundation Trust	Good	63
Portsmouth Hospitals NHS Trust	Good	64
5 Boroughs Partnership NHS Foundation Trust	Good	65
Surrey And Sussex Healthcare NHS Trust	**Good**	**66**
Cheshire and Wirral Partnership NHS Foundation Trust	Good	67
The Royal Bournemouth and Christchurch Hospitals NHS FT	Good	68
University Hospitals Coventry And Warwickshire NHS Trust	Good	69
Mid Cheshire Hospitals NHS Foundation Trust	Good	70
Camden and Islington NHS Foundation Trust	Good	71
East Lancashire Hospitals NHS Trust	Good	72
Cambridgeshire and Peterborough NHS Foundation Trust	Good	73
Royal Devon and Exeter NHS Foundation Trust	Good	74
West Middlesex University Hospital NHS Trust	Good	75
Blackpool Teaching Hospitals NHS Foundation Trust	Good	76
The Royal Wolverhampton NHS Trust	Good	77
The Whittington Hospital NHS Trust	Good	78
James Paget University Hospitals NHS Foundation Trust	Good	79
Hampshire Hospitals NHS Foundation Trust	Good	80
Hertfordshire Partnership University NHS Foundation Trust	Good	81
Milton Keynes Hospital NHS Foundation Trust	Good	82
Warrington and Halton Hospitals NHS Foundation Trust	Good	83
County Durham and Darlington NHS Foundation Trust	Good	84
Liverpool Women's NHS Foundation Trust	Good	85
Salford Royal NHS Foundation Trust	Good	86
Royal National Orthopaedic Hospital NHS Trust	Good	87
Devon Partnership NHS Trust	Good	88
University Hospitals Birmingham NHS Foundation Trust	Good	89
Derby Teaching Hospitals NHS Foundation Trust	Good	90
Ipswich Hospital NHS Trust	Good	91
Yeovil District Hospital NHS Foundation Trust	Good	92
Oxford University Hospitals NHS Foundation Trust	Good	93
Bedford Hospital NHS Trust	Good	94
Epsom And St Helier University Hospitals NHS Trust	Good	95
Staffordshire And Stoke On Trent Partnership NHS Trust	Good	96
Leicestershire Partnership NHS Trust	Good	97
Sandwell And West Birmingham Hospitals NHS Trust	Good	98
Royal Liverpool And Broadgreen University Hospitals NHS Trust	Good	99
Birmingham Women's NHS Foundation Trust	Good	100
The Hillingdon Hospitals NHS Foundation Trust	Good	101
Gateshead Health NHS Foundation Trust	Good	102
Solent NHS Trust	Good	103
Mersey Care NHS Trust	Good	104
York Teaching Hospital NHS Foundation Trust	Good	105
Somerset Partnership NHS Foundation Trust	Good	106
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Good	107
West Suffolk NHS Foundation Trust	Good	108
Bradford Teaching Hospitals NHS Foundation Trust	Good	109
Torbay and South Devon Healthcare NHS Foundation Trust	Good	110
Barnsley Hospital NHS Foundation Trust	Good	111
North Tees and Hartlepool NHS Foundation Trust	Good	112
Airedale NHS Foundation Trust	Good	113
Maidstone And Tunbridge Wells NHS Trust	Good	114
Southend University Hospital NHS Foundation Trust	Good	115
Countess of Chester Hospital NHS Foundation Trust	Good	116
South West Yorkshire Partnership NHS Foundation Trust	Good	117

Trust	Category	Rank
Dorset County Hospital NHS Foundation Trust	Good	118
Lancashire Teaching Hospitals NHS Foundation Trust	Good	119
South Tees Hospitals NHS Foundation Trust	Good	120
Tavistock and Portman NHS Foundation Trust	Significant Concerns	121
East London NHS Foundation Trust	Significant Concerns	122
Royal Brompton & Harefield NHS Foundation Trust	Significant Concerns	123
Northern Devon Healthcare NHS Trust	Significant Concerns	124
Central and North West London NHS Foundation Trust	Significant Concerns	125
South Warwickshire NHS Foundation Trust	Significant Concerns	126
Barnet, Enfield And Haringey Mental Health NHS Trust	Significant Concerns	127
Luton and Dunstable University Hospital NHS Foundation Trust	Significant Concerns	128
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Significant Concerns	129
Southern Health NHS Foundation Trust	Significant Concerns	130
St Helens And Knowsley Hospitals NHS Trust	Significant Concerns	131
King's College Hospital NHS Foundation Trust	Significant Concerns	132
Taunton and Somerset NHS Foundation Trust	Significant Concerns	133
Chelsea and Westminster Hospital NHS Foundation Trust	Significant Concerns	134
University College London Hospitals NHS Foundation Trust	Significant Concerns	135
Kingston Hospital NHS Foundation Trust	Significant Concerns	136
East And North Hertfordshire NHS Trust	Significant Concerns	137
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Significant Concerns	138
Stockport NHS Foundation Trust	Significant Concerns	139
Kent And Medway NHS And Social Care Partnership Trust	**Significant Concerns**	**140**
Birmingham and Solihull Mental Health NHS Foundation Trust	Significant Concerns	141
Lewisham and Greenwich NHS Trust	Significant Concerns	142
Peterborough and Stamford Hospitals NHS Foundation Trust	Significant Concerns	143
Kent Community Health NHS Foundation Trust	**Significant Concerns**	**144**
The Dudley Group NHS Foundation Trust	Significant Concerns	145
East Cheshire NHS Trust	Significant Concerns	146
The Princess Alexandra Hospital NHS Trust	Significant Concerns	147
The Royal Orthopaedic Hospital NHS Foundation Trust	Significant Concerns	148
Basildon and Thurrock University Hospitals NHS Foundation Trust	Significant Concerns	149
Leeds Community Healthcare NHS Trust	Significant Concerns	150
Sheffield Health & Social Care NHS Foundation Trust	Significant Concerns	151
South West London And St George's Mental Health NHS Trust	Significant Concerns	152
University Hospitals Of North Midlands NHS Trust	Significant Concerns	153
North Middlesex University Hospital NHS Trust	Significant Concerns	154
Derbyshire Healthcare NHS Foundation Trust	Significant Concerns	155
Weston Area Health NHS Trust	Significant Concerns	156
Hull And East Yorkshire Hospitals NHS Trust	Significant Concerns	157
Pennine Acute Hospitals NHS Trust	Significant Concerns	158
Cambridge University Hospitals NHS Foundation Trust	Significant Concerns	159
Coventry And Warwickshire Partnership NHS Trust	Significant Concerns	160
Calderdale and Huddersfield NHS Foundation Trust	Significant Concerns	161
Norfolk Community Health And Care NHS Trust	Significant Concerns	162
Imperial College Healthcare NHS Trust	Significant Concerns	163
Avon And Wiltshire Mental Health Partnership NHS Trust	Significant Concerns	164
University Hospitals Bristol NHS Foundation Trust	Significant Concerns	165
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Significant Concerns	166
Hinchingbrooke Health Care NHS Trust	Significant Concerns	167
Liverpool Community Health NHS Trust	Significant Concerns	168
Leeds and York Partnership NHS Foundation Trust	Significant Concerns	169
North Staffordshire Combined Healthcare NHS Trust	Significant Concerns	170
Leeds Teaching Hospitals NHS Trust	Significant Concerns	171
London North West Healthcare NHS Trust	Significant Concerns	172
Gloucestershire Care Services NHS Trust	Significant Concerns	173
Aintree University Hospital NHS Foundation Trust	Significant Concerns	174
Royal United Hospitals Bath NHS Foundation Trust	Significant Concerns	175
Wirral University Teaching Hospital NHS Foundation Trust	Significant Concerns	176

Trust	Category	Rank
Humber NHS Foundation Trust	Significant Concerns	177
North East London NHS Foundation Trust	Significant Concerns	178
Buckinghamshire Healthcare NHS Trust	Significant Concerns	179
North Bristol NHS Trust	Significant Concerns	180
Sussex Partnership NHS Foundation Trust	**Significant Concerns**	**181**
Barking, Havering And Redbridge University Hospitals NHS Trust	Significant Concerns	182
Northern Lincolnshire and Goole NHS Foundation Trust	Significant Concerns	183
Colchester Hospital University NHS Foundation Trust	Significant Concerns	184
University Hospitals of Morecambe Bay NHS Foundation Trust	Significant Concerns	185
George Eliot Hospital NHS Trust	Significant Concerns	186
Royal Berkshire NHS Foundation Trust	Significant Concerns	187
Birmingham Community Healthcare NHS Trust	Significant Concerns	188
Mid Essex Hospital Services NHS Trust	Significant Concerns	189
Royal Free London NHS Foundation Trust	Significant Concerns	190
Southport And Ormskirk Hospital NHS Trust	Significant Concerns	191
Gloucestershire Hospitals NHS Foundation Trust	Significant Concerns	192
Plymouth Hospitals NHS Trust	Significant Concerns	193
Black Country Partnership NHS Foundation Trust	Significant Concerns	194
South Tyneside NHS Foundation Trust	Significant Concerns	195
Chesterfield Royal Hospital NHS Foundation Trust	Significant Concerns	196
Sheffield Teaching Hospitals NHS Foundation Trust	Significant Concerns	197
The Rotherham NHS Foundation Trust	Significant Concerns	198
Croydon Health Services NHS Trust	Poor	199
West London Mental Health NHS Trust	Poor	200
Brighton And Sussex University Hospitals NHS Trust	**Poor**	**201**
University Hospital of South Manchester NHS Foundation Trust	Poor	202
University Hospitals Of Leicester NHS Trust	Poor	203
St George's University Hospitals NHS Foundation Trust	Poor	204
West Hertfordshire Hospitals NHS Trust	Poor	205
Western Sussex Hospitals NHS Foundation Trust	Poor	206
Northampton General Hospital NHS Trust	Poor	207
Barts Health NHS Trust	Poor	208
Ashford and St Peter's Hospitals NHS Foundation Trust	Poor	209
Sherwood forest Hospitals NHS Foundation Trust	Poor	210
Norfolk and Norwich University Hospitals NHS Foundation Trust	Poor	211
Isle of Wight NHS Trust (acute sector)	Poor	212
Kettering General Hospital NHS Foundation Trust	Poor	213
Shrewsbury And Telford Hospital NHS Trust	Poor	214
Walsall Healthcare NHS Trust	Poor	215
Lincolnshire Partnership NHS Foundation Trust	Poor	216
East Kent Hospitals University NHS Foundation Trust	**Poor**	**217**
North Essex Partnership University NHS Foundation Trust	Poor	218
Worcestershire Acute Hospitals NHS Trust	Poor	219
United Lincolnshire Hospitals NHS Trust	Poor	220
Heart of England NHS Foundation Trust	Poor	221
Isle of Wight NHS Trust (mental health sector)	Poor	222
Norfolk and Suffolk NHS Foundation Trust	Poor	223
North Cumbria University Hospitals NHS Trust	Poor	224
Alder Hey Children's NHS Foundation Trust	Poor	225
Medway NHS Foundation Trust	**Poor**	**226**
Manchester Mental Health and Social Care Trust	Poor	227
Mid Yorkshire Hospitals NHS Trust	Poor	228
Royal Cornwall Hospitals NHS Trust	Poor	229
East Sussex Healthcare NHS Trust	**Poor**	**230**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-13 CQC Quality improvement Plan update — Chief Nurse

This report provides information on the March update of the CQC Quality Improvement Plan.

Compliance action 6 relating to overnight discharges from ITU: There are continued challenges with out of hours transfers from ITU related to patient flow pressures. During February 10 patients, 8 at TWH and 2 at Maidstone were transferred out of hours for clinical need. This compares with 10 in January, 11 in December (all TWH). All mitigation is in place including 24/7 outreach service and each case is reviewed and discussed at the operational site meetings. The opening of the new 38 bed ward on 19th March will ease capacity challenges and thus improve our ability to further reduce any discharges out of hours from ITU.

With compliance action 9 –Cultural/linguistic, an engagement and equality and diversity lead has now been appointed and will commence in post 1st April 2016.

Evidence / Assurance: The evidence required for this quality improvement plan has been gathered over the past 11 months. Operational leads have been requested to send their supporting evidence as actions have been completed. There is a central database where the evidence is hyperlinked to the action plan. Whilst some evidence is in document form, such as clinical guidance and audits, other evidence is better tested in practice, such as patient facilities. The Associate Director of Quality Governance has been working with directorates to provide the evidence required and in April will be commencing an internal assurance program. This program mirrors the CQC style inspections and will include the testing in practice of the Quality Improvement Plan actions assigned to the area being reviewed. This will provide further assurance of change as a result of this comprehensive action plan.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance.

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

CQC Quality Improvement Plan

Assurance Report March 2016

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in February 2015. This is a monthly report (commenced April 2015 onwards), following which the main Quality Improvement Plan is updated. This report is submitted to the Trust Management Executive, the Trust Board, TDA and the CQC and is shared with local commissioning groups. A summary is published on the MTW intranet and MTW website.

This report presents the progress of the Enforcement notice and Compliance actions.

Overview of progress to date

The enforcement notice was lifted by the CQC in 2015. Of those compliance actions still to be fully completed there has been reassuring progress demonstrated with some awaiting final audits to demonstrate full compliance / change in practice.

Compliance actions – Critical care

There are continued challenges with out of hours transfers from ITU. During February 10 patients, 8 at TWH and 2 at Maidstone were transferred out of hours for clinical need. This compares with 10 in January, 11 in December, 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. All mitigation is in place and each case is reviewed and discussed at the operational site meetings. The opening of the new 38 bed ward on 19th March in will ease capacity challenges and thus improve our ability to further reduce any discharges out of hours from ITU.

There has been no other progress with the 2 other Compliance actions; CA 9 –Cultural/linguistic needs and CA 14 – Joint management of children with surgery, as their actions are not yet due to complete.

Status of plan

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. Some of the original actions, once completed have resulted in other actions being required which is simply an evolution of the situation for example compliance action 2, action 3b.

There is an element of judgment on the RAGB rating, based on the update and evidence provided and discussions.

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

	Blue	Fully Assured
	Amber	Not running to time and / or more assurance required
	Green	Running to time, in progress / not running to time but sufficient assurance of progress
	Red	Not assured / actions not delivering required outcome

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities		Enforcement notice lifted. Completed compliance action
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		Completed compliance action
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Completed compliance action
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		Completed compliance action.
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		During February 10 patients, 8 TWH and 2 at Maidstone were transferred out of hours for clinical reasons (none routine). This compares with 10 in January, 11 in December, 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. ***Red over 5, Amber 5 or less. Green less than 3.***
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		Completed compliance action
CA 8 – ICU washing facilities	Jacqui Slingsby Matron, Critical Care Directorate		Completed compliance action
CA 9 – Cultural/linguistic needs	Richard Hayden Deputy Director of Workforce		Substantive Equality and Diversity Lead post for MTW has been appointed and commences employment 1st April 2016.
CA 10 – CDU Privacy and dignity	Lynn Gray Associate Director of Nursing		Completed compliance action

CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		Completed compliance action
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		Completed compliance action
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 14 – Joint management of children with surgery	Hamudi Kisat / Jonathan Appleby Clinical Directors		Audit in progress results due in May
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		Completed compliance action
CA 16 – Incident reporting + lessons learnt	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 17 – Corporate clinical governance	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		Completed compliance action

Enforcement Notice

Enforcement Action			REF	Directorate	Issue Identified	Action /s	Lead	Date to be completed	Evidence Required	Outcome/success criteria
Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Cleanliness and Infection Control Cleanliness and infection control 12. (1) The registered person must, so far as reasonably practicable, ensure that – (a) Service users; (b) Persons employed for the purpose of the carrying on of the regulated activity; and (c) Others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2), (2) The means referred to in paragraph (1) are (a) The effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection; People who use services and others were not protected against the risks associated with health care associated infections because the trust had failed to ensure that an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infections, with specific regard to water quality and safety and more specifically, themanagement and control of Legionella. Regulation 12(1)(a)(b)(c)(2)(a)(c).	**Executive Lead: Glenn Douglas**	**Date compliance will be achieved by: January 2015**	**EN1**	Estates and Facilities Management	The annual water sampling for legionella was six months overdue at Maidstone Hospital	1. Internal Investigation undertaken 2. External review undertaken 3. Water Hygiene Management Action Plan developed and implemented 4. Governance around water hygiene management reviewed and new system of robust Governance implemented 5. Risk Assessments and Sampling testing undertaken 6. Authorised Engineer (Water) appointed 7. Estate Management and Audit review of processes with a number of new appointments have been made within the senior team of Estates Services ensuring Authorised Persons in each technical element. The planned preventative maintenance schedule is currently being reviewed to ensure all statutory requirements are incorporated. In addition a comprehensive schedule is being developed for audit purposes. The internal auditing will be triangulated by the inspections, risk assessments and annual report undertaken and issued by the Authorised Engineer (Water) who provides the independent assurance and validation.	Jeanette Rooke	Completed 14th January 2015	Report produced outlining Governance, testing results and audit processes External review report Certificates of sampling Ongoing Agenda and Minutes of meetings	Water hygiene Management is compliant with statutory requirements with robust governance and management in place

Report submitted with all actions completed. Enforcement notice lifted; will continue to be monitored through the governance structure in place. RAGB = BLUE

Compliance action 1			CA1	
Issue: *The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts)	New PEWS charts now in use in all paediatric areas and old charts removed	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communication via meetings	30/6/15 Fully implemented 1/9/15 only audit outstanding	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol approved and added to back of new PEWs charts in use			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	Training of new starters implemented Ongoing training of staff Audits underway to provide evidence of implementation: PEWs audit Inpatients completed 25th September PEWs audit Ambulatory completed 28th September PEWS audit ED completed Nov PEWs audit to be submitted via trust audit team			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	All medical and nursing training completed for nerve centre. Ongoing training for new staff organised as part of induction package Spot check audit shows 100% compliance with use of PEWS on Nervecentre	6. Compliance audit from Nervecenter	31/12/15 Actions completed. Audit due for completion end January 2016	
Action Plan running to time: YES				
Evidence submitted to support update (list): New PEWS Chart, audit results				
Assurance statement :				
PEWs chart in place and training implemented across all relevant departments. Nerve centre now in place across unit – to revert to paper PEWs if nerve centre fails				
Areas of concern for escalation:				
None				

Compliance action 2				CA2
Issue: *Contrary to the core standards of the Intensive Care Society: There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Morning week-end ward rounds on both units implemented	Implemented and monitored on electronic rota	1. Anaesthetic electronic rota showing allocation of intensivists at weekends to site allocation 2. Business plan including risk assessment, mitigations and staffing analysis against core standards 3. TME Meeting minutes where business case considered and decision made 4. Audit of patients medical notes documenting weekend Consultant reviews	1/2/15	
2a. Second ward round at weekend is taking place at both units. Risk assessment undertaken with mitigations in place as required 2b. Second ward round at weekend in person	2a. Risk assessment undertaken with mitigation in place 2b. 1-8compliant rota in place to ensure a second ward round in person at weekend occurs.		2a. 31/3/15 2b. 1/10/15	
3a. The rota for the intensivists reviewed in line with the requirements of the ICS core standards 3b. Rota fully meeting the ICS requirements	3a. Rota reviewed 3b. Rota in line with ICS requirements now in place (1-8 compliant) Locum gaps being covered internally while recruitment of intensivist takes place. 3 fixed term generalists recruited to support theatre lists Consultant Job plans under review		3a. 31/3/15 3b. 1/10/15	
4. Business case for additional intensivists developed and considered	Agreed at TME June 2015.		17/6/15	
5. Mitigation in place for non-compliance	Mitigation part of CQC intensivist risk assessment		30/6/15	
6. Recruitment achieved	Recruitment is on-going with successful recruitment to one post in September 2015		1/4/16	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
Concerns still arise in regards to recruitment of 4 WTE suitably qualified intensivists. Further risk assessment and mitigation to be developed if recruitment campaign is ineffective.				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

Compliance action 3				CA3
Issue: *Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant.	This has now been assessed by the clinical director Risk assessment completed and on risk register. New rota commenced September 2015 will have intensivists based at hospital thus ensure compliance	1. Report from Clinical Director outlining each Consultant's travel distance and confirmation of each Consultants ability to respond within 30 minutes. 2. Any delays in responding to be reported as incidents (DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews New complaint 1-8 rota implemented in September 2015	31/5/15	
2. Risk assessment to be undertaken where travel times exceed 30mins	Completed and on risk register. Following changes to the previous rota intensivists will be based on the site which is now within the 30 minute rule mitigating the risk. Risk assessment to be reviewed as now compliant.		31/5/15	
3. Ward round compliance actions in CA2	Please refer to summary in CA2		3a. 31/3/15 3b. 1/10/15	
Action Plan running to time: YES				
Evidence submitted to support update (list): Risk assessment				
Assurance statement :				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

Compliance action 4			CA4	
Issue: *Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to ICU*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Consider option of ring-fencing ITU bed for admission	Discussed at Trust Management Executive: the ring-fencing of ITU bed will be implemented where possible. This has not happened consistently due to ICU bed demand; consideration is given on a daily basis at the site meetings where critical care capacity is available across the trust going into the night.	1. Minutes of TME meeting where ring-fencing option discussed 2. SOP for ITU admissions, transfers and discharges. SOP for managing critically ill patient when ITU is full 3. Site report documentation 4. Monthly performance data 5. DATIX IR1 completed for each patient who has a delayed admission to ITU due to inability to move wardable patients.	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	SOP ratified at Standards committee in August 2015		31/5/15 New date: 31/8/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	Review completed and Standard Operating Procedure in place		30/4/15 New date: 30/11/15 30/1/16	
4. ITU referrals & those patients requiring ITU will be identified and discussed at each site meeting and priorities escalated as appropriate.	Attendance at each site meeting by Shift leader/matron in place. Associate Director responsible for the site ensures ITU capacity and demand is discussed at each site meeting and plans put in place with clinical teams to transfer out as appropriate. ITU referrals are consultant to consultant and raised to both the Clinical site team and Matron/Shift leader in ICU. Clinical priorities identified by the Consultant intensivist		1/4/15	
5. When no prospect of ITU capacity available on either site then arrangements for transfer to another unit will be made.	Consider escalation feasibility before any transfer. Critical care capacity within Trust reviewed before transfer outside of organisation. National Emergency bed service already in place.		1/1/15	
Action Plan running to time: YES (to new date)				
Evidence submitted to support update (list):				
Assurance statement :				
Completed				

Compliance action 5				CA5
Issue: *Contrary to the core standards of the Intensive Care Society: Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 4 hours*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure to be developed relating to ITU discharges	Operational Policy which incorporates discharge policy ratified at August 2015 at Standards Committee	1. SOP for ITU admissions, transfers and discharges. 2. Site report documentation. 3. Monthly performance data 4. DATIX incident report completed for each patient who has a delayed discharge from ITU.	31/5/15 New Date: 31/8/15	
2. Transfers out of ITU to be followed up on a named patient basis at each site meeting	In place at site meetings		1/4/15	
3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Monthly delayed discharge performance data captured on performance dashboard and within monthly unit reports. Performance against milestones reported at monthly CQUIN board. Incident forms completed for each delay, clinical site team identified as handlers. Trust operational plan in place to open an additional ward at TWH by Jan 2016 with the aim to ease patient flow across the trust.		30/5/15	
Action Plan running to time: completed				
Evidence submitted to support update (list):				
Assurance statement :				
Action completed				
Areas of concern for escalation:				

Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc. Displayed in site team on communications board	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 2000 hrs at the latest. No patients to be routinely transferred from ITU after 2000.	Core standards state: *'Discharge from Critical Care should occur between 07:00hrs and 21:59hrs' (2.12)* During February 10 patients, 8 at TWH and 2 at Maidstone were transferred out of hours for clinical need. This compares with 10 in January, 11 in December, 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. Incident reports were raised each time. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues. Trust operational plan in place to open an additional ward at TWH in Feb 2016 with the aim to ease patient flow across the trust.		1/3/15 (for robust patient identification and tracking New date (for new ward) 31/3/16	
Action Plan running to time: Yes (revised date)				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
Continuing issues with patient flow across the trust impacting on ICU patient discharges.				

Compliance action 7				CA7
Issue: *The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011))*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Siobhan Callanan, ADN planned care*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Business Case approved	Approved	1. Rota showing 24 hour / 7day cover 2. Review of service and performance data via Directorate Clinical Governance meetings	27/1/15	
2. Recruitment to posts	All Band 7 posts recruited into		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	24 hour 7 day out-reach service rota commenced		1/10/15	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
The Outreach service will be provided across the trust 24/7 from 9th October, prior to this a 24 hour service will be available over the weekends on 25th, 26th and 27th September and 2nd, 3rd and 4th October				
Areas of concern for escalation:				
None				

Compliance action 8				CA8
Issue: *Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Conversion of an existing toilet to a patient toilet & bathroom facility at Tunbridge Wells Hospital	Bathroom facilities for patients have always been in place at TWH and contains a toilet within the shower room. The staff toilet which is co-located to the existing facility has been re-assigned and designated as a patient toilet, with appropriate signage	1. Photo of Toilet / shower facilities appropriate for patient use 2. Confirmation at Executive / Non Executive walkabout	1/4/15	
2. Provision of appropriate patient washing facilities within Critical Care at Maidstone Hospital	Shower room available and two designated patient toilets, one which has disabled access; all in use.		1/4/15	
Action Plan running to time: **completed**				
Evidence submitted to support update (list):				
Assurance statement :				
Photographs: Submitted with April update All areas commissioned. Executive walk round at Maidstone – Avey Bhatia & Steve Tinton 13/4/15 at Tunbridge Wells – Paul Sigston 14/4/15 Reviewed and seen on 6th July internal review – fully compliant				
Areas of concern for escalation:				

Compliance action 9				CA9
Issue: *The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have*				
Lead: *Richard Hayden, Deputy Director Human Resources*	**Operational Lead:** *Richard Hayden, Deputy Director Human Resources & John Kennedy, Deputy Chief Nurse*			
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Appoint a dedicated lead for Equality and Diversity for Trust	Interim E&D Lead appointed April 2015 Funding for substantive post holder agreed, to be advertised Q4. Lead will not start until new financial year. Chief Nurse is E&D Board Lead	1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patients, Healthwatch and community groups (with actions developed and monitored as required)	1/9/15 (for interim) New date substantive 1/04/16	
2. Develop an E&D awareness programme for all staff	E&D training 89% compliant against 85% target (April 2015). Benchmarking & intelligence from partner Trust to inform awareness programme and roll out plan that is both department specific and generic. This will be developed by the substantive E&D Lead.		1/10/15 New date 31/07/16	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations	WF strategy approved June 2015. E&D priorities included & supported by project plan approved Workforce Committee September 2015 BME Forum second meeting 21/9/15. SEC BME Chair in attendance. Trust WRES data reviewed. Trust has partnered with Stonewall to support LGBT staff. Data submitted for Stonewall Equality Index		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – Recirculated July 2015. Translation service currently being re-procured		1/2/15	
5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion	Meeting and agreed contact for best practice with Leicester Partnership Trust. Work will not progress until lead is in post		1/6/15	
6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities	Under assessment with intention to commission external support Priority Plan to be finalised linked to EDS2 grading plan. WRES data presented to Board 30/9/15. Comprehensive review will be undertaken when substantive postholder in post (see 1)		1/4/16 New date 31/07/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch	Under assessment with patient and Carers Groups. Healthwatch will also act as final approver for EDS2		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Development of new Diversity Management Group. First meeting 30 October 2015.		1/9/15	
Action Plan running to time:	YES			
Assurance statement :				
In progress				
Areas of concern for escalation:				

Compliance action 10				CA10
Issue: *Dignity and privacy of patients was not being met in the Clinical Decisions Unit (CDU)*				
Lead: *Akbar Soorma, Clinical Director*		**Operational Lead:** *Lynn Gray, ADN emergency*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Options appraisal for addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)	CDU became single sexed (female) from 8th June with 2 rooms on MAU being used if required for men. SOP circulated. This has been maintained to date.	1. Options appraisal paper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee 3. Site report documentation	1/5/15	
2. Agree preferred option and implement	Long term plan has been discussed within the Directorate and two options are being scoped (AAU and MAU) to find an alternative area for CDU capacity from January 2016 once the new ward opens. Both options provide DSSA compliance.		Option 1: 1/4/16 Option 2: 1/10/15	
3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place	CDU capacity and demand continues to be discussed at each site meeting. Site report reflect s any variance from SOP over the last 24 hours (none have occurred to date).		1/4/15	
4. To link in with Trust wide work around patient flow and action TW30	Review of pathways to support the A&E flow has occurred as a result of AAU opening in May.		30/5/15	
Action Plan running to time: completed				
Evidence submitted to support update (list):				
Assurance statement :				
CDU single sex (all female). All staff aware of standard operating procedure and mandatory single sex CDU status.				
Areas of concern for escalation:				

Compliance action 11				CA11
Issue: *The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Wilson Bolsover, Deputy Medical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit	a) Discussed with Clinical Directors 7/10/15 b) This has been considered. Decision following audit is to not pursue this at this time c) Audit completed with staff involvement. Action plan developed	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15 new date 1/9/15	
2. Review induction programme for new Doctors to ensure adequate training provided.	a) Induction for trainees includes legibility of notes (15.4.15) b) Clinical Tutors asked to add in requirement to avoid loose papers (7.5.15) c) College tutors to be prompted about induction for non-training grades once (b) completed.		1/5/15	
3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made	a) Discussed at CD Board (6.5.15). No perceived need to change the case note records ahead of implementation of electronic records.		1/6/15	
4. Record keeping audit to be included in case reviews at Directorate CG Meetings	Underway in most Directorates with ongoing scrutiny of documentation standards		1/9/15 new date 1/12/15	
Action Plan running to time: Yes (new date)				
Evidence submitted to support update (list):				
Assurance statement :				
Audit shows reasonable compliance, however some areas for improvement. Action plan implemented.				
Areas of concern for escalation:				
None				

Compliance action 12				CA12
Issue: *Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.*				
Lead: *Jeanette Rooke, Director of Estates and Facilities*		**Operational Lead***: John Sinclair, Head of Quality, Safety, Fire & Security*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Provide documentation outlining the joint partnership with our contractor in regards to the provision of training.	Completed and closed	1. Agreed documentation on joint partnership arrangements 2. Induction Attendance / compliance report on all existing security staff to Security Group 3. TNA document 4. Report on training compliance to Security Group 5. Certificates of training 6. Certificates of training	18/5/15	
2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training	Completed		1/4/15 New date: 1/7/15	
3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels	Completed and closed		1/5/15	
4. Review compliance with all training requirements against existing security team	Completed. Security contractor has 100% compliance rate in accordance with BSIA and ACS		1/5/15	
5. The Security Manager to provide training logs for the SMART Risk Assessment Training undertaken through one to one sessions with all security officers.	Completed – evidence in the security SLA minutes		1/4/15 New date: 1/7/15	
6. All current security staff to be booked onto and attend Mental Health Awareness Training and dementia awareness training	All security staff booked on sessions		1/8/15	
Action Plan running to time: completed				
Evidence submitted to support update (list):				
Assurance statement :				
L&D have allocated all our Security Team login details for the on-line induction.				
Areas of concern for escalation:				

Compliance action 13				CA13
Issue: *The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.*				
Lead: *Avey Bhatia, Chief Nurse*		***Operational Lead:*** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	***Monthly summary update on progress***	***Evidence required***	***Action completion date***	***Rating***
1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction	Leaflet completed Distribution completed	1. Leaflet + audit of distribution and staff engagement through survey 2. fully implemented intranet and web page 3. Datix Staff survey + reporting figures / by profession 4. Education presentation + staff survey 5. Newsletter every month	1/5/15 Distribution excepted to be completed 1/9/15	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	Allocated lead for this work. Intranet completed. Bolder reporting incident button already changed on intranet front page Work completed on Website		Intranet 1/6/15 Website 1/10/15 New date 1/12/15	
3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media	Datix upgrade completed. Datix review group established. Reporting page streamlined and quicker. DATIX app now loaded on the new Ipad's to be used in clinical practice		1/6/15 New date for completion of all actions: 1/8/15	
4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year	Revised RCA training commenced New patient safety /quality training programme developed		1/9/15 Revised RCA training 28/2/16	
5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	Monthly articles in Governance Gazette		Monthly	
Action Plan running to time: ***Yes***				
Evidence submitted to support update (list):				
Assurance statement :				
This action plan is well underway with good progress.				
Areas of concern for escalation:				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Clinical Director attended surgical CG meeting to present papers	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	SOP completed and circulated to staff		1/6/15 New date: 1/9/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams Audit planned and awaiting results		1/8/15 Clinical Director: Audit allocated but results not expected until May 2016	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	New Governance framework developed and agreed with implementation commenced December 2015		1/9/15 New date: 1/12/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): SOP				
Assurance statement :				
Areas of concern for escalation:				
None				

Compliance action 15				CA15
Issue: *The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Karen Carter-Woods, Risk and Governance Manager*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. A full review of the directorate risks	On-going review and updating at Directorate meetings	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting 3. Meeting agendas	1/5/15	
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register plus induction groups	Staff updates on-going: new 'Risk Update' publication distributed		16/6/15	
3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Already standing agenda item at Directorate meetings Now standing agenda item at Paediatric Clinical Governance meeting		16/6/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Risk update, Induction agenda's, CG agenda's				
Assurance statement :				
Work on-going within the directorate to increase staff awareness and involvement with paediatric risks				
Areas of concern for escalation:				
Nil				

Compliance action 16				CA16
Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*				
Lead: *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. Assc. Director Quality Governance and Patient Safety attended Anaesthetic Clinical Governance meeting in May 2015 to discuss the Trust Incident reporting system in place and take questions.	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anesthetist and intensivists	1/2/15	
2. Staff leaflet to include reminder about rationale for single reporting system	Leaflet completed, distribution due for completion 1/9/15		1/5/15	
3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust.	In May's edition of the Governance Gazette		1/5/15	
4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Attended Anaesthetic Clinical Governance meeting 14th May and updated attendees on reporting system		1/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): e-mail confirmation + Governance Gazette + Leaflet + CG meeting minutes				
Assurance statement :				
This compliance action has been completed				
Areas of concern for escalation:				
None				

Compliance action 17				CA17
Issue: *There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.*				
Lead: *Paul Sigston, Medical Director* *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Following full collaborative process (external governance review) New Trust wide Governance framework and agreed with implementation commenced December 2015. New committee structure in place and communication with staff being rolled out January 2016	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1/9/15 New date: 31/12/15	
2. Development of a MTW Clinical Governance Strategy	Document on the Clinical Governance process and framework in place		1/7/15 New date: 31/12/15	
3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness	MTW mortality review process and procedure has been reviewed and developed according to new NHS England and NTDA guidance. This process needs to be adopted and embedded. New Trust Mortality Surveillance Group (formally Mortality Review Group) developed in principle with first meeting planned for February 2016 Mortality e-form solution is delayed due support for the e-Forms solution being budgeted for 2016/17. This will be re-visited April 2016		1/8/15 New date: 1/12/15	
4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Communication and engagement with senior clinicians as to roles and responsibility. Return rates for mortality reviews are average 50%.		1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Mortality review completed, however process needs to be embedded in practice.				
Areas of concern for escalation:				
Delay in e-form solution due to software costs being in 2016/17 budget planning. Revised Mortality process requires all in-hospital mortalities to be reviewed. Concerns raised about consultant SPA time in which to do this.				

Compliance action 18				CA18
Issue: *The arrangement for the management and administration of topical anaesthetics was ineffective.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure for the administration of topical anaesthetics for children to be developed and implemented	Information regarding PGDs including Standard operating policy available on intranet Lead for ward identified – Sister Rochelle Gilder PGD now available in all areas in purple PGD folders	1. SOP for children's services. 2. Audit of prescription charts. 3. Training records of staff undertaking PGD training	1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	PGD audit completed for ambulatory and inpatient areas PGD audit information currently being collated and updated with trust audit department PGD audit shows 100% compliance		1/6/15 New date 30/11/15 for audit completion	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	All key staff fully trained and signed off (100%) with ongoing programme for new starters		1/7/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): audit to be submitted				
Assurance statement :				
All actions completed				
Areas of concern for escalation:				
None				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-14	The process for ensuring institutionalised learning following Serious Incidents	Chief Nurse

Summary / Key points

This report provides information on the process for ensuring institutionalised learning following Serious Incidents.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance.

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

LEARNING FROM SERIOUS INCIDENTS

Learning from serious incident to prevent recurrence is the central focus of the Serious Incident Framework (NHS England, 2015). They clearly specify that the most recent publication has been amended in order to '*focus attention on the identification and implementation of improvements that will prevent recurrence of serious incidents, rather than simply the completion of a series of tasks'* (p6). This aligns with the national acknowledgement that effecting real improvements in safe and quality care requires staff engagement and cultural change.

The recent staff survey (2015) identified that MTW was better than average for overall staff engagement and staff satisfaction with the quality of work and patient care they are able to delivery. A higher percentage of staff reported errors, near misses or incidents than in the previous survey (2014) which was positive. The trust was also rated GOOD in the newly published Learning from Mistakes League Table by NHS Improvement.

With this in mind there are several processes already in place at MTW that promote learning and ensuring improvements and changes are implemented following a serious incident:

1. The use of case study presentations at Directorate Clinical Governance meetings to share and discuss the learning from Serious Incident investigations. This is a common way of local learning and agreeing actions and changes required. Please see missed C-spine fractures cluster review example in appendix 2
2. Trust-wide learning is shared within the Governance Gazette newsletter (see appendix 1) that has now been published every month for the last 15 months. The Gazette is sent to all wards and departments via the post and contains summaries and case studies from Serious Incidents, complaints and inquests. The Gazette was also widely disseminated at the Clinical Governance roadshow in November 2015 giving it better coverage throughout the Trust.
3. Key messages and learning from Serious Incidents are shared at the Trust Clinical Governance Committee with an expectation that Directorate representatives take and share the information at more local and staff meetings, disseminating learning through the Directorates
4. Never Event postcards were developed in 2014 that summarised the case and learning. These were widely distributed then and re-distributed at the November roadshow.
5. Executive and Non-Executive walkabouts allow discussion with staff and a direct review of clinical care and the patient experience.

The above is further enhanced by the recent introduction of four elements that will support learning and provide enhanced assurance around improvements:

1. Implementation of revised Serious Incident framework and process (shared at last Trust Board) that will enable a consistent high quality investigation and a focus on learning and improvement. To support this it has been proposed to change the name of the SI panel to the 'Learning and Improvement panel', aligning with the new national SI framework focus.
2. The implementation of a 'testing in practice' program of internal assurance based on the CQC 5 domains. This includes reviewing action plans from all SI's and red complaints from the last 12 months and checking / reviewing the expected changes in the clinical / department areas. This will be carried out within a different Directorate each month starting April 2016 and a report will be shared with the Directorate and at TME
3. Central Patient Safety Team will be monitoring and following up action plans from SI's until completion from April 2016, enabling completion of reports in a timely and comprehensive manner. The central team will be rolling out a spot check audits on action plan completion.
4. Learning and improvements as a result of serious incident investigations will be shared with staff on the intranet in a case study series to be rolled out from May 2016 onwards

Appendix 1: Examples of articles from Governance Gazette:

May 2015

ISSUE 09 May 2015 mtw Governance Gazette

In this issue

Learning Lessons

Patient Safety—what to do after a fall?

Patient safety and wellbeing is at the heart of what we do at MTW but what happens when a patient falls whilst they are in our care? How do we ensure that we reduce the risk of injury or harm to the fallen patient?

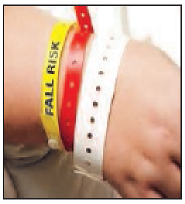
At MTW all patient falls are reported and investigated. For incidents that have resulted in injury or harm to a patient, a root cause analysis is undertaken to investigate and ascertain the following:

- **What happened?**
- **Why it happened?**
- **How it happened?**
- **What can be done to stop it happening again to someone else?**

From the root cause analysis (RCA), action plans are put in place to ensure that learning is identified and disseminated to all staff. In this way we can all ensure that our patients receive safe care.
It is important to remember that when a patient falls whilst in our care, we undertake appropriate immediate actions to reduce risk of injury or harm to the patient. This can be done by undertaking an initial assessment of the patient and environment. Where the patient appears to be injured or where there is suspicion of injury, action needs to be taken to reduce further injury.

In one case, a patient had fallen and was assisted back to bed before a full assessment was carried out; the patient was later found to have a significant injury (fracture). This is likely to have caused further pain and discomfort to the patient and also the potential for displacement of the fracture. In instances where injury is suspected or obvious, the patient should be assessed, first aid given and the transfer from the floor should be undertaken using a scoop stretcher in conjunction with a hoist or Hoverjack. Assessment and monitoring of the patient is key to ensuring that your patient's wellbeing is maintained and that we do not cause any unintentional harm to the patient through our actions or inactions. After a fall, the patient may initially appear unharmed however it is good practice to ensure the patient is reviewed and any signs or symptoms are followed up and investigated. Last year we had an incident where a patient was found to have a fractured hip three weeks after a fall she had just after admission. She was reviewed and analgesia given for pain, but the follow up actions were not prompt with regards to investigating the nature of her pain and what had been limiting her mobility. It is vital that we listen to our patients and what they are telling us so that we can take prompt and appropriate action to help them and reduce the risk of further suffering and harm.

Delay in ordering and obtaining results of investigations can also result in unnecessary distress to our patients. We saw an example of this when a patient with a suspected fracture following a fall was sent for an x-ray overnight, but the medical team was not made aware until the following afternoon that the x-ray had yet to be reviewed. Consequently there was a delay in diagnosing the patient's fracture and arranging the remedial surgical intervention required for the patient.
At MTW we have an action card that offers guidance to staff on how to respond following a patient fall. Please ensure you refer to the action cards so that when a patient has fallen we take appropriate and timely action to minimise the impact and reduce the risk of harm. Each ward has been provided with a laminated copy to be displayed at staff base. Copies can also be found on q-pulse or obtained from the Falls Prevention Practitioner on 07734 884563 .



By Gust Rickwood, Falls Prevention Practitioner

July 2015

Governance Gazette

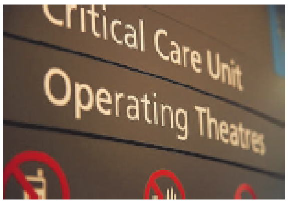
In this issue

Serious Incidents: focus on sepsis

By Jenny Davidson, Associate Director of Governance, Quality and Safety

At a recent Serious Incident panel we reviewed several cases where sepsis was the central issue. In all cases there were lessons to be learnt around how we recognise, detect and escalate cases of sepsis.

In one case a lady arrived in A&E with a presentation of severe pain under her arm. On observation she had low blood pressure, normal pulse and normal temperature. On investigation, she was found to have normal white cell count and a raised CRP. She was given pain relief and fluids and was reviewed by several teams. 12 hours after arrival, sepsis was suspected and IV antibiotics commenced, but she became unwell and was admitted to ICU with severe sepsis. After further treatment she made a full recovery.



LEARNING: In the absence of other probable causes clinicians should assume the cause of hypotension is sepsis and start antibiotics promptly. As a result of this we need to all be more sepsis aware. In response we will be introducing a sepsis screening tool in A&E, with posters to remind staff and some additional teaching to improve sepsis knowledge.

Another case involved an elderly gentleman with co-morbidities who arrived in A&E with lower abdominal pain and a history of becoming more confused during the day. The ambulance staff had found he was pyrexial and had given him paracetamol. He was reviewed and assessed by the stroke nurse, provided with care and vital sign observations were done. No PAR score was undertaken, however his blood pressure was found to be slightly low and blood tests showed lactate 2.6. He was admitted to a ward 4 hours after coming into hospital, but was not placed on the handover sheet overnight. The gentleman's observations deteriorated overnight and the nurse discussed this with the doctor on several occasions. The gentleman was reviewed by the doctor in the morning where sepsis was diagnosed. Sadly the gentleman died later that morning.

LEARNING: This difficult case highlights the importance of using the PAR score to identify patients at risk which will help to ensure they commence on the correct pathway. It also highlights the importance of being alert to sepsis even when the symptoms are less obvious or usual. This case also points to how effective communication is central to ensuring all information is passed on, especially during handover from ambulance to A&E staff. It is suggested the use of a handover tool such as SBAR would be helpful, especially when escalating concerns.

PATIENT SAFETY = SHARING LEARNING

October 2015

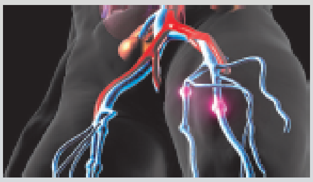
In this issue

Venous Thromboembolism (VTE) Serious Incident

We recently had a case where an omission of medication may have contributed to a probable pulmonary embolism (a blood clot on the lung); this is a salient reminder of the importance of following all steps in the VTE assessment and action process.

A lady arrived on the maternity unit for care. After some time on the unit, the lady needed to have an emergency caesarean section. Theatre paperwork indicates that the lady had anti embolic stockings & intermittent pneumatic compression devices (IPCD) in theatre but there was no documentation of use of mechanical compression post procedure.

The usual practice is for Dalteparin (a drug that helps to prevent or treat blood clots) to be given 6 hours post procedure, so should have been due at 18:30, however the Dalteparin was prescribed same day to be given at 22:00. Despite this the Dalteparin was not actually given until the following morning at 06:00 hrs. There was no reason clinically for this delay and no reason was documented in the notes. At 08.00 the lady became unwell with shortness of breath and complaining of chest tightness. Her observations were checked and her oxygen saturations had dropped. The lady was immediately treated and investigated for a blood clot. Following a scan it was decided to treat the lady for a pulmonary embolism. The lady was discharged on anticoagulation medications which she will continue to take for 3 months.



MTW are Research Recruitment Leaders

A big 'well done' and 'thank you' to the following services who are really putting MTW on the map when it comes to delivering research -

The respiratory service – for being the only team in the country to recruit more asthma patients than planned to the Laser trial during August and September.

The ophthalmic service – for being second only to the study centre (Kings, London) in the number of patients with wet age related macular degeneration to the Star study

Rheumatology service – for recruiting the first patient in the country to the Reflections study looking at moderate to severe arthritis.

It is fantastic that MTW staff are striving to be the best at providing new, innovative treatments for the benefit of patients

WELL DONE ALL!

Learning for sharing:

Please ensure actions from VTE risk assessments are fully implemented and documented. Documentation needs to be clear (*if you don't document it, it didn't happen*) with a rationale for any changes to planned care or missed medications.
Remember VTE can be a serious and life-threatening event which we can reduce the risk of with careful risk assessment and use of mechanical devices and medications. Let's all be VTE aware and keep patients safe!

ber 2015

February 2016

Pressure Ulcer Incidence

John Kennedy, Deputy Chief Nurse

The Trust has had two facility acquired incidents of category 3 and 4 pressure damage last July/August. This is the first incidence of facility acquired damage of this magnitude.

The learning from the RCAs for both these cases includes the following:

- Need for heightened awareness of risk from all staff groups
- Consideration to be given for alternative approaches to positional changes particularly in non-ward areas.
- Communication between disciplines and departments and treating and/or transferring patients known to be at high risk of developing pressure damage

In one case we had a patient who was being treated on a daily basis in a non-ward area without a nurse in attendance. The patient's condition was such that a nurse escort was not essential to safety during transfer. There was no evidence that the receiving department was made aware of the need for positional changes, or that the receiving department recognised this risk and sought advice and/or help.

The other case was a patient with multiple complex health issues that did not fit 'neatly' into any particular care pathway. There was evidence of conflicting advice from different non-medical specialists who were not directed to work together on the development of a plan specifically for this patient.

In both cases is has to be noted that there was strong evidence of good clinical care overall. In both cases (1: possibly avoidable, 1: unavoidable) there was strong evidence that event/s that caused the damage occurred elsewhere in the patient's care pathway. These 'missed' opportunities, in isolation, were insignificant but the aggregated effect was significant pressure damage.

In the possibly avoidable case, if all health care professionals were sighted on the increased risks of pressure damage it *may* have altered the outcome. The example of this would be the overall awareness of pressure damage at the beginning of the year when we had significant bed pressures, but no increase in facility acquired pressure damage.

Trust Wide Learning from Incidents January 2016

Sarah Miles, Patient Safety Manager

Learning organisations are open and transparent when things go wrong in order to identify learning and prevent or reduce the risk of errors reoccurring.
In most cases the lessons we can learn from one error in one department can be applied to other areas of the Trust. Here we have shared with you the cases and learning and summarised where we can all learn from what has happened. Good clinical governance relies on each and every member of staff who works in an organisation recognising where they too can make changes and improvements to keep patients and staff safe.

Here are some Trust wide learning that we can share from January's Incidents:

There were **8 mortuary incidents** where the **paperwork** accompanying the patient was **incorrect**: please ensure all paperwork is checked and the description of any jewellery left on the patient is accurate for example: a yellow /gold coloured ring with a white stone.

There were **over 30 incidents** reported in the month relating to **blood traceability**: you must trace every blood unit on the blood tracking system and there is a green sticker on the luggage label reminding you to do so. If you do not have access then please speak with your line manager for training to be arranged. If you can not trace a unit of blood then contact blood transfusion for advice.

There were **11 hospital acquired category 2 pressure damage** this month—ensure patents are risk assessed and body mapped on admission or transfer to your area, early interventions are essential. Documentation of care given and description of pressure areas are essential to allow early detection of any deterioration.
If a patient declines care you must ensure they understand the risks and have the capacity to make this decision for themselves. This must be clearly documented. Contact the Tissue Viability Nurses through Switchboard if you have any questions about pressure ulcers or want support for a patient.

Clinical Ethics Committee: Call for members

Dag Rutter (Consultant in Palliative Medicine) and Ann Munro (Trust Clinical Ethicist) welcome all expressions of interest for the Trust 's Clinical Ethics Committee—next meeting Friday 13 May 2016 Lecture room 3, Education Centre, TWH

Recent discussion topics—End of life nutrition and hydration, DNACPR best practice, informed medical consent (Montgomery 2015)
Contact: dag.rutter@nhs.net OR annmunro@nhs.net

Editor: Gina Knott

Appendix 2

Missed C Spine fractures

In 2014/2015 there was an identified cluster of 5 missed c-spine fractures in six months. This was picked up both by the department and by the central patient safety team.

In response a cluster review was undertaken to identify general themes and commonalities between the cases to see where learning / change needed to occur.

3 major themes were identified:

	Failure to image appropriately	Out of hours	Frail Elderly patient
Patient 1	✗	✓	✗
Patient 2	✓	✓	✓
Patient 3	✓	✗	✗
Patient 4	✓	✓	✓
Patient 5	✗	✓	✓

From this a systemic cross department approach was agreed and implemented.
2014 NICE Guidance on Head and Cervical Spine Imaging (CG176) into A&E departmental protocols and A&E junior staff were given updates and training.
A&E and Radiology colleagues worked together and, following discussion at Departmental Clinical Governance meeting, the following was implemented:

1. Erroneous requests for X-rays of the cervical spine in the over 65's are automatically upgraded to a CT.
2. Where a CT head (for traumatic reason) is requested this is automatically upgraded to include the cervical spine in patients over 65 years old

Since the implementation of this new approach there have been **no** further missed C-Spine fractures to date. This demonstrates an effective change in practice reducing the chance of reoccurrence of a Serious Incident.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-15	**Planned & actual ward staffing for Feb 2016** (incl. comparison of the Nursing establishment for each Ward with the actual staff employed 15/16)	**Chief Nurse**

The enclosed report shows the planned v actual nursing staffing as uploaded to UNIFY for the month of February 2016. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'. Financial and key nurse-sensitive indicators have also been included as an aid to triangulation of both efficient and effective use of staff.

This is evident in a number of areas where there has been an unplanned increase in dependency. A number of wards have required additional staff, particularly at night, to manage patients with altered cognitive states, increased clinical dependency or with other mental health issues. Notable in this respect are John Day, Chaucer and Ward 20.

Escalation areas account for the remainder of the over-fill. These areas remain the same; namely UMAU, SAU and to a lesser extent MSSU. MSSU have had increased demand as much of the elective work load has been undertaken here to free beds in the main surgical wards.

When the fill rate is only marginally over 100% by +/- 5% this is normally related to working patterns which required staff to work an additional shift periodically as long shifts result in a staff member either working over or under their contracted hours in any given month.

A number of wards have had a shift in RN: CSW ratios, in these areas this was a considered action based on professional judgement, available skill mix and patient acuity and dependency. Notably this applies to ward 10, Peel and Cornwallis.

Ward 12 has a number of EU nationals awaiting NMC PIN and continues to have some level of vacancy.

Maidstone Stroke Unit has recently experienced a number of changes in staff. The Ward Manager and the Stroke CNS have a plan in place to maintain recruitment momentum and to develop existing staff to enable them to provide thrombolysis bleep cover.

Accident & Emergency (A&E) Departments overall fill rates are good against planned staffing levels. As expected Tunbridge Wells A&E had an increased RN fill rate, particularly at night.

The RAG rating for the fill rate is rated as:
Green: Greater than 90% but less than 110%
Amber Less than 90% OR greater than 110%
Red Less than 80% OR greater than 130%

The principle being that any shortfall below 90% may have some level of impact on the delivery of care. However this is dependent on both acuity and dependency. Acuity is the term used to describe the clinical needs of a patient or group of patients, whilst dependency refers to the support a patient or group of patients may need with activities such as eating, drinking, or washing.

High fill rates (those greater than 110%) would indicate significant changes in acuity and dependency. This results in the need for short notice additional staff and as a consequence may have a detrimental impact on the quality of patient care.

The exception reporting rationale is RAG rated according to professional judgement against the following expectations:

- The ward maintained a nurse to patient ratio of 1:5 – 1:7

- Acuity and dependency within expected tolerances
- Workforce issues such as significant vacancy
- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set bout below:

The key underlying reasons for amber overall ratings are vacancy resulting in an adverse shift of the RN to CSW ratios and high levels of acuity and dependency.

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Appendix 1 – Nursing Establishments (inc comparison of the Nursing establishment for each Ward with the actual staff employed 15/16)

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Feb'16		Day		Night		Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	FFT Response Rate	FFT Score - % Positive	Falls	PU - ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	82.0%	107.8%	87.1%	103.4%	9.8%	75.0%	5	0		Risk managed with support from the Stroke CNS and Clinical Site Practitioner team. Recruitment plan in place, as well as development plan to develop more RNs able to cover thrombolysis bleep.	107,868	115,107	(7,239)
MAIDSTONE	Romney	100.0%	87.4%	98.3%	108.6%			1	0			66,973	73,793	(6,820)
MAIDSTONE	Cornwallis	81.9%	124.1%	96.6%	93.1%	17.4%	100.0%	2	0		Accepted risk, as overall acuity decreased. Dependency needs were met.	93,341	106,211	(12,870)
MAIDSTONE	Coronary Care Unit (CCU)	75.9%	N/A	100.0%	N/A	10.5%	100.0%	0	0		Supported by staff on Culpepper. Unit is co-located on Culpepper. Staff required to support escalation in other areas. Considered approach to manage patient acuity & dependency across both CCU and	104,039	113,150	(9,111)
MAIDSTONE	Culpepper	98.3%	100.0%	100.0%	106.9%	31.6%	100.0%	1	0					
MAIDSTONE	John Day	96.1%	120.7%	100.0%	124.1%	3.1%	100.0%	4	3		7 days with increased acuity (Tracheostomy pt.) needing enhanced levels of care, plus 2 days for special requirement for a challenging patient.	105,856	214,808	(108,952)
MAIDSTONE	Intensive Treatment Unit (ITU)	96.6%	85.7%	101.3%	N/A	50.0%	100.0%	0	0			162,337	171,151	(8,814)
MAIDSTONE	Pye Oliver	81.4%	106.9%	100.9%	93.1%	6.8%	80.0%	4	0		Nurse in charge supervisory role not covered, plus 7 shifts not filled. Minimal impact noted on direct patient care.	95,666	82,008	13,658
MAIDSTONE	Chaucer	100.0%	131.9%	100.0%	146.0%	14.0%	100.0%	5	1		patient requiring special 24/7 for 26 days.	79,299	152,002	(72,703)
MAIDSTONE	Lord North	103.5%	93.9%	102.3%	100.0%	13.3%	100.0%	0	0			97,050	103,725	(6,675)
MAIDSTONE	Mercer	93.1%	94.3%	101.1%	100.0%	3.3%	100.0%	5	0			91,166	100,101	(8,935)
MAIDSTONE	Edith Cavell (MOU)	82.3%	100.0%	100.0%	134.5%	0.0%	0.0%	0	1		10 nights of specials required during the month.	134,418	58,760	75,658
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	99.5%	89.8%	131.0%	217.2%	3.2%	91.7%	0	0		Escalated: trolleys converted to beds throughout the month.	119,337	143,682	(24,345)
TWH	Acute Stroke	95.4%	100.0%	97.7%	96.6%	39.1%	88.9%	5	0			76,565	79,796	(3,231)
TWH	Coronary Care Unit (CCU)	96.6%	58.6%	98.9%	N/A	57.7%	93.3%	0	0		Considered approach to use of CSW. Support provided to escalation areas.	57,300	64,575	(7,275)
TWH	Gynaecology	100.0%	96.7%	100.0%	100.0%	12.5%	91.7%	0	0			66,261	73,080	(6,819)
TWH	Intensive Treatment Unit (ITU)	110.3%	100.0%	110.3%	N/A			0	0		Escalated beds open.	185,375	200,729	(15,354)
TWH	Medical Assessment Unit	97.3%	103.4%	132.8%	112.6%	13.1%	88.9%	7	0		AAU escalated throughout the month.	151,252	190,927	(39,675)
TWH	SAU	118.4%	224.1%	151.7%	400.0%			1	0		Escalated throughout the month, providing staffing and support to Recovery	65,750	152,120	(86,370)
TWH	Ward 32	86.2%	103.4%	100.0%	100.0%	2.5%	100.0%	2	1		Acceptable/managed reduction, as co-located on the Private Patient Unit; staff cross-cover as required.	119,912	146,408	(26,496)
TWH	Ward 10	82.1%	108.0%	93.8%	137.5%	8.6%	100.0%	5	0		12 nights with requirement enhanced observation/specials. Considered approach to RN:CSW ratio shift during the day whilst recruitment place starts to impact	124,165	127,198	(3,033)
TWH	Ward 11	94.4%	111.9%	94.6%	133.9%	20.3%	100.0%	2	0		13 nights with requirement for enhanced observation/specials.	125,584	124,139	1,445
TWH	Ward 12	78.5%	121.8%	92.2%	105.2%	4.9%	100.0%	13	2		RN:CSW ratio variation a considered approach as recruitment plan starts to impact. Number of EU RNs awaiting PIN &/or competency sign-off. Of the 13 falls, 7 occurred between 8am and midnight.	108,139	117,178	(9,039)
TWH	Ward 20	93.9%	139.7%	100.0%	187.9%	29.2%	85.7%	8	3		Cohort nursing for confusion and falls risk throughout the month. In addition there were two incidents of 1:1 specialling required. All have been risk assessed and approved by matron and AD.	122,805	154,526	(31,721)
TWH	Ward 21	106.2%	90.8%	113.8%	88.5%	1.7%	100.0%	8	0		RN:CSW ratio variation at night to cover increased acuity. 13 nights required additional RN cover.	119,912	141,821	(21,909)
TWH	Ward 22	92.2%	90.8%	100.0%	106.9%	70.6%	100.0%	6	1			93,043	126,816	(33,773)
TWH	Ward 30	88.7%	116.7%	97.4%	102.3%	1.5%	100.0%	6	3		Considered approach for RN:CSW ratio in the morning due to change in patient acuity.	121,746	126,494	(4,748)
TWH	Ward 31	94.0%	87.1%	95.5%	98.8%	18.8%	77.8%	1	2			136,057	144,026	(7,969)
TCH	Stroke Rehab	83.9%	108.6%	103.4%	100.0%	62.5%	100.0%	3	0		Always 2 RNs on duty, cross-cover arrangements with neighbouring ward when required.	57,413	53,718	3,695
TWH	Ante-Natal	100.0%	89.7%	100.0%	96.6%			0	0		CSW fill rate low due to increased levels of sickness.			
TWH	Delivery Suite	94.3%	69.0%	101.5%	93.1%	13.5%	93.2%	1	0			590,515	610,330	(19,815)
TWH	Post-Natal	102.9%	93.0%	97.4%	88.5%			0	0					
TWH	Gynae Triage	101.7%	93.1%	96.6%	93.1%			0	0			11,354	10,927	427
TWH	Hedgehog	98.9%	62.0%	99.4%	90.8%	21.2%	89.4%	0	0		Priority given to covering nights, as escalated into Woodlands.	186,192	160,321	25,871
TWH	Birth Centre	101.7%	96.6%	100.0%	100.0%			0	0			65,394	66,539	(1,145)
TWH	Neonatal Unit	102.0%	72.8%	104.9%	55.2%			0	0		Reduced fill rate for CSW a considered approach, as a number of empty cots as a result of restricted admissions.	160,643	168,483	(7,840)
MAIDSTONE	MSSU	151.4%	100.0%	112.5%	N/A	0.0%	0.0%	0	0		RN:CSW ratio variation due to increased demand on service to meet elective surgical activity.	55,535	45,283	10,252
TWH	Peel	85.2%	108.6%	86.2%	100.0%	25.3%	100.0%	1	0		Accepted risk, as overall acuity decreased. Dependency needs were met.	80,271	75,895	4,376
TWH	SSSU	119.0%	114.3%	N/A	N/A	0.0%	0.0%	2	0		Escalated with cross-cover to theatres	36,096	22,061	14,035
MAIDSTONE	A&E	96.2%	89.7%	101.7%	86.2%	6.4%	82.0%	0	0			161,634	208,129	(46,495)
TWH	A&E	102.1%	97.7%	110.7%	94.8%	5.5%	90.0%	0	0			252,724	257,320	(4,596)
											Total Established Wards	**4,588,987**	**5,083,337**	**(494,350)**
											Additional Capacity beds	39,045	96,532	-57,487
											Other associated nursing costs	2,411,631	2,744,547	-332,916
											Total	7,039,663	7,924,416	-884,753

RAG Key

Underfill

Over fill

Appendix 1

Nursing establishments

Introduction

This paper provides an update regarding the nursing establishments for each ward and A&E with a comparison to actual staff employed, including bank and agency usage in month 10 of the financial year.

During 2015/16 there has been an increasing trend in nursing spend in particular agency and bank usage.

As part of Business planning and budget setting, establishments for every ward and A&E have been reviewed with directorates ensuring robust roster plans are in place. This exercise has been completed in conjunction with a review of the current bed base (including escalation beds).

A draft establishment pack has been discussed at the Executive weekly meeting.

2015/16 nursing establishments

Annex A of this paper includes a snapshot of the wards and A&E departments nursing establishments compared against the actual staff in post at month 10 (January), inclusive of bank and agency usage.

Approach for setting 2016/17 establishments

The following approach has been followed for setting 2016/17 establishments, with the overarching principle that nurse patient ratios will be dependent on type of ward, throughput, acuity, dependency, geography, professional judgement and evidence based.

The following principles have been applied:

- Registered / unregistered nursing ratio dependant on the ward type.
- 23% headroom includes mandatory training, sickness and annual leave
- Ratio based on standardised shift patterns (early, late, night and long days where appropriate)
- Vacancies budgeted for at mid-point plus agency premium (1.55) for a specified time period depending on recruitment timeframe, based on planning discussions
- Maternity leave included within budgets where known – action to review budgeting for maternity leave centrally
- Review the use of specialling as part of budget setting
- In addition to this approach there is a safe staffing policy and an escalation policy for operational changes in year that may result in establishments being reviewed

Next Steps

The following next steps have been agreed to enable finalising the nursing establishments for next financial year.

- Challenge meetings are scheduled for the 21st, 22nd and 30th March with each ward. The challenge meetings will include Operational, Nursing, Human Resources and a Finance representative.
- Budget sign off by Chief Nurse, ADNs, Matrons and Ward Managers, rotas to be used from the 1st April and included as part of the overall financial plan
- Ensure that agreed rotas as part of budget setting correlate with Roster-Pro
- A review of the specialling policy will be completed, with ward establishments being set excluding specials.
- Explore the opportunity of co-horting medically fit patients and moving the establishment for these wards to a 1:10 nursing ratio

Annex A

Annex A - Snapshot of the wards and A&E departments nursing establishments compared against the actual staff in post at month 10 (January), inclusive of bank and agency usage

Department	Ward	Type of Ward (Current)	Nurse Grade	Budget (WTE) v Worked (WTE)					
				Budgeted		Worked Total Worked		Vacancy / (Over Estab)	
MEDICINE1	STROKE UNIT (PREV WD14) TWH	Inpatient (24-7)	Qualified - RGN	18.65	27.50	17.40	25.88	1.25	1.62
			Unqualified - CSW	8.85		8.48		0.37	
AESITEMAID	ACCIDENT & EMERGENCY (MAI)	A&E	Qualified - RGN	42.66	49.82	50.40	60.16	(7.74)	(10.34)
			Unqualified - CSW	7.16		9.76		(2.60)	
AESITETW	ACCIDENT & EMERGENCY (TWH)	A&E	Qualified - RGN	63.98	84.72	59.26	73.59	4.72	11.13
			Unqualified - CSW	20.74		14.33		6.41	
MEDICINE1	WARD 21 PEMBURY	Inpatient (24-7)	Qualified - RGN	30.72	44.11	32.54	45.61	(1.82)	(1.50)
			Unqualified - CSW	13.39		13.07		0.32	
CARDIOLOGY	CORONARY CARE UNIT (TWH)	Inpatient (24-7)	Qualified - RGN	14.99	17.11	15.02	17.83	(0.03)	(0.72)
			Unqualified - CSW	2.12		2.81		(0.69)	
MEDICINE1	WARD 12 PEMBURY	Inpatient (24-7)	Qualified - RGN	26.06	41.05	24.83	41.72	1.23	(0.67)
			Unqualified - CSW	14.99		16.89		(1.90)	
CARDIOLOGY	CATHETER LABORATORY (TWH)	Daycase (Mon to Fri)	Qualified - RGN	7.00	8.00	12.03	16.66	(5.03)	(8.66)
			Unqualified - CSW	1.00		4.63		(3.63)	
MEDICINE1	WARD 20 PEMBURY	Inpatient (24-7)	Qualified - RGN	25.37	44.67	23.44	47.97	1.93	(3.30)
			Unqualified - CSW	19.30		24.53		(5.23)	
MEDICINE1	MERCER WARD (MAI)	Inpatient (24-7)	Qualified - RGN	20.59	37.79	24.91	41.71	(4.32)	(3.92)
			Unqualified - CSW	17.20		16.80		0.40	
MEDICINE1	CULPEPPER WARD (MAI)	Inpatient (24-7)	Qualified - RGN	25.38	33.95	25.00	33.31	0.38	0.64
			Unqualified - CSW	8.57		8.31		0.26	
MEDICINE1	ROMNEY COMMUNITY WARD MAI	Inpatient (24-7)	Qualified - RGN	14.55	28.10	14.69	27.09	(0.14)	1.01
			Unqualified - CSW	13.55		12.40		1.15	
MEDICINE1	CHAUCER WARD [NEW MEDICAL]	Inpatient (24-7)	Qualified - RGN	18.76	27.49	27.70	51.73	(8.94)	(24.24)
			Unqualified - CSW	8.73		24.03		(15.30)	

Department	Ward	Type of Ward (Current)	Nurse Grade	Budget (WTE) v Worked (WTE)					
				Budgeted		Worked Total Worked		Vacancy / (Over Estab)	
MEDICINE1	FOSTER CLARKE WINTER WD MAI	Inpatient (24-7)	Qualified - RGN	0.00	0.00	24.33	29.71	(24.33)	(29.71)
			Unqualified - CSW	0.00		5.38		(5.38)	
MEDICINE1	PYE OLIVER WARD [MEDICAL]	Inpatient (24-7)	Qualified - RGN	24.81	36.56	21.02	34.65	3.79	1.91
			Unqualified - CSW	11.75		13.63		(1.88)	
AESITEMAID	URGENT MED AND AMBULATORY UNIT	Inpatient (24-7)	Qualified - RGN	29.75	43.86	29.00	45.75	0.75	(1.89)
			Unqualified - CSW	14.11		16.75		(2.64)	
MEDICINE1	STROKE UNIT MAID	Inpatient (24-7)	Qualified - RGN	26.42	37.01	25.87	42.45	0.55	(5.44)
			Unqualified - CSW	10.59		16.58		(5.99)	
AESITETW	MEDICAL ASSESSMENT UNIT TWH	Inpatient (24-7)	Qualified - RGN	35.16	58.82	47.82	69.33	(12.66)	(10.51)
			Unqualified - CSW	23.66		21.51		2.15	
MEDICINE1	WARD 22 PEMBURY	Inpatient (24-7)	Qualified - RGN	16.45	33.90	17.15	38.47	(0.70)	(4.57)
			Unqualified - CSW	17.45		21.32		(3.87)	
MEDICINE1	WHATMAN WINTER WARD MAI	Inpatient (24-7)	Qualified - RGN	0.00	0.00	7.63	9.31	(7.63)	(9.31)
			Unqualified - CSW	0.00		1.68		(1.68)	
CARDIOLOGY	CATHETER LABORATORY (MAI)	Daycase (Mon to Fri)	Qualified - RGN	5.17	6.17	2.97	5.03	2.20	1.14
			Unqualified - CSW	1.00		2.06		(1.06)	
MEDICINE1	NEURO REHAB WARD (TCH)	0	Qualified - RGN	12.78	20.18	10.24	18.84	2.54	1.34
			Unqualified - CSW	7.40		8.60		(1.20)	

Department	Ward	Type of Ward (Current)	Nurse Grade	Budget (WTE) v Worked (WTE)					
				Budgeted		Worked Total Worked		Vacancy / (Over Estab)	
SURGERY	MAIDS SHORT STAY SURG UNIT	Daycase (Mon to Fri)	Qualified - RGN	16.84	20.26	11.96	15.82	4.88	4.44
			Unqualified - CSW	3.42		3.86		(0.44)	
SURGERY	CORNWALLIS WARD [NEW SURGERY]	Inpatient (24-7)	Qualified - RGN	19.94	29.03	19.20	28.72	0.74	0.31
			Unqualified - CSW	9.09		9.52		(0.43)	
SURGERY	PEALE WARD (SURGERY)	Inpatient (24-7)	Qualified - RGN	20.85	23.58	17.68	23.01	3.17	0.57
			Unqualified - CSW	2.73		5.33		(2.60)	
SURGERY	WARD 10 PEMBURY	Inpatient (24-7)	Qualified - RGN	31.97	45.64	21.06	42.13	10.91	3.51
			Unqualified - CSW	13.67		21.07		(7.40)	
SURGERY	WARD 11 PEMBURY	Inpatient (24-7)	Qualified - RGN	30.23	42.36	24.24	41.13	5.99	1.23
			Unqualified - CSW	12.13		16.89		(4.76)	
SURGERY	DAY SURGERY WARD (14A) PEM	Inpatient (24-7)	Qualified - RGN	16.98	20.35	26.81	40.27	(9.83)	(19.92)
			Unqualified - CSW	3.37		13.46		(10.09)	
SURGERY	SHORT STAY SURGICAL UNIT TWH	Daycase (Mon to Fri)	Qualified - RGN	9.47	10.87	4.56	6.96	4.91	3.91
			Unqualified - CSW	1.40		2.40		(1.00)	
TRAUMAORTH	WARD 30 PEMBURY	Inpatient (24-7)	Qualified - RGN	29.81	44.36	24.78	40.99	5.03	3.37
			Unqualified - CSW	14.55		16.21		(1.66)	
TRAUMAORTH	WARD 31 PEMBURY	Inpatient (24-7)	Qualified - RGN	34.76	50.59	23.99	44.45	10.77	6.14
			Unqualified - CSW	15.83		20.46		(4.63)	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-16	**Declaration of Compliance for Delivering Single Sex Accommodation (DSSA) Compliance Statement**	**Chief Nurse**

The Trust is required to publish a declaration of compliance for delivering single sex accommodation (DSSA) on its website, and to update it annually. This has been amended to reflect the new ward on the Tunbridge Wells Hospital site and is shown below:

Declaration of compliance

Maidstone and Tunbridge Wells NHS Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care (ICU), Coronary Care (CCU), or the Acute Stroke Unit, or when patients actively choose to share (for instance Chemotherapy Day Unit).

All in-patient care at Tunbridge Wells Hospital at Pembury is provided in single rooms including Intensive Care, Coronary Care and Acute Stroke. All rooms (except Intensive Care) have en-suite toilet and shower facilities.

Acute Medical Unit at Tunbridge Wells Hospital will provide in-patient care in 4 bedded bays. These bays will be single sex, and will have appropriate gender specific toilets and washing facilities adjacent to them.

If our care should fall short of the required standard, we will report it through our governance structures to the Trust Board. We have an audit mechanism in place to make sure that we do not misclassify any of our reports.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

To approve

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – 23rd March 2016

3-17	**Update on the FY17 Business Planning Process**	**Director of Finance**

Summary / Key points

The following report provides information on…

1 The approach taken to develop the Trust's annual Business Plan for the Financial Year 2016/17 (FY17), and
2 The development of Business Plan to the Trust Development Agency (TDA) following the initial submission on 8th February 2016

This document supports the paper '16-17 Financial Plan'

Which Committees have reviewed the information prior to Board submission?

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Discussion and decision

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

1 Internal business planning update

1.1 Context

The purpose of this update to The Board is twofold:

- Firstly to provide a summary of the approach taken to develop the Trust's annual Business Plan for the Financial Year 2016/17 (FY17), and
- Secondly, following an initial submission of the Business Plan to the Trust Development Agency (TDA) on 8th February 2016, to provide an update on its development, a final version of which is due to be submitted on 11th April 2016 following approved by the Trust Board.

1.2 Directorate planning process

Throughout the process Business Planning Steering Group (BPSG) members have worked with the Directorates to support them in the development of their business plans. The BPSG have tasked the operational leads for ensuring that Directorate plans are aligned to the clinical strategy, LTFM, local health and care system commissioning strategies before scrutiny by the Trust management executive, the Workforce Committee and Finance Committee.

This integrated and collaborative approach has been taken to ensure that corporate plans suitably reflect bottom-up Directorate planning whilst, at the same time, ensuring Directorate plans are consistent with the strategic direction assumed by the Trust and to gain assurance that all relevant matters have been accurately taken into account.

This, as an ongoing process, has involved:

- The dissemination of centrally held information to Directorates to inform the business planning process at a detailed level
- Ongoing one-to-one informal meetings with Directorates to review and agree baseline positions for activity demand and capacity, workforce requirements, capital planning, efficiency and savings plans (ESPs)
- The development by Directorates of individual Business Plans and presentations supported by BPSG 'deep dive' meetings with individual clinical directorates
- Attendance by Directorate clinically-led management teams at a minimum of two formal Executive-led challenge meetings
- Collation of Directorate information to ensure that all planning is cohesive and triangulated throughout the Trust thereby informing the overall Trust business and financial planning through to setting the budget for FY17, and
- Culminating in clinical presentations to a joint meeting of the Trust Management Executive (TME) and Board, prior to
- The Trust Board reviewing and formally approving the final FY17 Trust Business Plan at their meeting on 25 March, in advance of its submission to the TDA on 11th April 2016.

1.3 Activity demand and capacity planning

Activity assumptions have been based on demographic growth plus in year waiting list growth. A baseline has been derived by extrapolating a 2015/16 outturn which has been uplifted for demographic growth derived and steady state waiting list. Assumptions have been shared with and reviewed by directorates against their local knowledge of demand and who have confirmed this can be met through one of the following:

- Use of current capacity

- Previously planned and agreed new capacity
- Efficiency improvements
- Agreed use of independent sector
- Agreed Commissioner QIPP schemes to reduce demand.

The Trust has carried out an assessment of current capacity against the demand requirements. Work has been ongoing with the Directorates who have continued to review and update their detailed capacity plans linked to both workforce and financial impact. Consistency and reasonableness test have been carried out to ensure that demand and capacity outputs are credible, congruent with and meet planning expectations.

Plans are currently able to maintain present referral to treatment (RTT) position and deliver cancer projections. The Directorates plans currently exclude addressing the backlog that has grown in the last three months, due to capacity constraints in particular trauma and orthopaedics. FY16 M1 to M8 actual activity has been extrapolated into a full year's forecast outturn. This forecast outturn has been uplifted for demographic growth and is being used to inform negotiations with our Commissioners. In addition, improvement trajectories for all the core access standards have been established and agreed with our host Commissioner. These include A&E, diagnostic waits, RTT current backlog and 62-day cancer targets with further work being undertaken to look at any probable impacts on capacity.

1.4 Planning and impact on quality

Quality, as core day to day business, is embedded within all aspects of care, performance and development in order to meet the Trust's guiding principles of patient care, safety and quality of care. The Trust's Business Plan sets out an expected deficit of £24.5m though the Trust is focusing on improving this position through the provision of quality-driven services and continued challenge to ensure value for money.

1.5 Workforce

The Trust has adopted a rigorous workforce planning process, ensuring that clinical directors, supported by multi-disciplinary senior clinicians, are at the heart of the decision making process within their respective Directorates:

- Workforce assumptions are largely based on the levels of delivery of care in 2015/16
- Directorate business plans have been developed using benchmarked workforce metrics and triangulating with finance and activity
- Nursing and medical establishments continue to be reviewed to ensure delivery of key quality indicators
- The Trust has a strong pipeline of nurse recruitment and, as substantive staffing increases, is forecasting a reducing utilisation of temporary staff in 2016/17
- Directorates will continue to work on initiative plans to attract staff to work for the organisation and target opportunities overseas to reduce vacancies, where appropriate.
- All Directorate workforce plans have been formally approved by the relevant Clinical Director ensuring a multi-disciplinary approach in the formation of the local plan

The Trust has a number of workstreams to ensure compliance against the TDA/Monitor rules and to reduce the reliance upon temporary staffing, these include 'Temporary Staffing' work stream, with the Chief Operating Officer as the Executive Sponsor, 'Procurement' work stream, with the Director of Finance as the Executive Sponsor and 'Nursing Efficiencies', with the Chief Nurse as the Executive Sponsor. These workstreams ensure compliance in accordance with the TDA/Monitor rules, adherence to the Price Caps and reduction in demand against temporary staffing, in terms of recruitment and retention.

1.6 Finance

The draft Financial Plan has been collated with the starting point as FY16 outturn, adjusted for full year effects, expected activity changes in relation to holding waiting lists steady state, demographic growth, service changes, normalisation in FY16 and non-recurrent items. The draft financial plan includes the impact of the FY17 national tariff and demographic growth which equates to £7.8m. Our efficiency programme incorporates the expected improvements from agency negotiations for capped rates and recruitment initiatives for key nursing vacancies. The Trust is also considering a range of approaches to managing its resource requirements, eg the use of managed service arrangements.

Work is ongoing to ensure that robust bottom-up budgets are in place for directorates, inclusive of expected demand and quality improvements required, to align to the Trust's strategic objectives. The executive-led business planning sessions with Directorates have been continuing since November 2015 and ensure the Trust's financial plans are suitable, feasible and acceptable against the Trust's strategy.

The final plan submission will bridge from FY16 M10 outturn forecast with material bridging items identified and explained.

The Trust's five year capital programme is focussed on delivering the clinical strategy, driving access and operational performance improvements and reducing backlog and clinical risk to ensure appropriate patient safety and experience, within an efficient environment. The Trust has re-prioritised and scaled down its capital programme in the light of the constraints on external capital and also to reflect the stretching of its existing asset base; it will also access charitable funding to support its capital investment, particularly in cardiology and oncology.

1.6 Sustainability and Transformation Planning

The Trust's operational plans are, in part, driven by the requirements of the emerging regional Sustainability and Transformation Plan (STP), which itself is driven by the Forward View and the connected local priorities. Whilst the Trust is committed to this approach, such a major transformation of primary care, community based health and social care, and locally delivered secondary care services into fully integrated and significantly enhanced services will, necessarily, impact the Trust on several fronts:

- Out of hospital care
- Hospital based care
- Centralisation of specialist services.

With a transition of service provision moving from the acute to the community setting, the Trust will need to identify new models of hospital care, target the potential capacity to expand the specialist service provision it offers, reshape its cost base and service delivery models to be able to deliver high quality and affordable care provided by an appropriately trained and engaged workforce. Consequently, the Trust is currently working through its strategy to support its forward planning.

1.7 Conclusion / Next Steps

The annual plan is due for submission to NHS Improvement (NHSI) on the 11th April.

NHS England (NHSE) has recently issued further guidance regarding the sign off of acute contracts with commissioners. Whilst the final date for contract agreement to avoid arbitration is 25 April, the national deadline for signing of contracts remains the 31 March. Where agreement has not been reached by 23 March, and a material gap exists Trust and commissioners will be expected to put themselves forwards for formal mediation.

The Trust has agreed to participate in the STP advisory group that has been set up by Monitor / TDA. The group will help review and steer the development of a template for STP footprint finances. This group will be in place for the next two to three months.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-18	**Senior Information Risk Owner update** (including approval of the Information Governance Toolkit submission for 2015/16)	**Chief Nurse (Senior Information Risk Owner / SIRO)**

The Board are advised that as Senior Information Risk Owner (SIRO), I have received and been satisfied with assurance reports in relation to Information Governance from the Information Asset Owners of the Clinical Directorates as well as from the Heads of Corporate functions.

Information Governance Management Framework (IGMF)
The Information Governance Committee reviewed the IGMF on 8 July 2015. The Caldicott Guardian and Data Protection Officer were happy to approve the framework as meeting the needs of the organisation for the coming year.

IG Toolkit v13

- The Trust is required to make its year end submission to the Information Governance (IG) Toolkit by 31st March 2016. During the year evidence rolled over from prior years has been reviewed to ensure it meets the requirements of the 2015/16 Toolkit and additional evidence has been posted where possible to support the Trust position.
- At July 2015 the Trust target was to maintain a minimum Level 2 position against all 45 requirements and if possible to achieve a number of requirements at Level 3. The Board are advised that the Trust is achieving the minimum Level 2 score against each of the 45 requirement of the Toolkit. A number of the requirements will be met at level 3.
- Internal Audit (TIAA) have undertaken an independent review of evidence pertaining to 15 of the 45 Toolkit requirements and the Trust has received a 'reasonable assurance' audit report. A copy is available to Board members on request (from the Trust Secretary).
- The Board is asked to support a recommendation for year- end submission of **not less** than 72% (satisfactory). This is a reduction of 2% on the final 2014/15 submission but is likely to change (increase). A detailed breakdown of the Toolkit requirements and proposed submission details by attainment level is enclosed, at Appendix A.

Information Governance Partnership Board (IGPB)
The Trust has played an active role during the year on the Kent and Medway Information Governance Partnership Board. The IGPB is accountable to the Joint Kent Chief Executive's Group consisting of representatives from 17 organisations, of which 14 are Local Authorities. The IBPB is responsible for maintaining the Kent and Medway Information Sharing Agreement.

Incident Reporting
During 2015/16 the Trust had no Information Governance-related incidents which required notification to the Department of Health and the Information Commissioner's Office.

Information Risks
The Board are advised that one new ICT risk was added to the Trust risk register at Directorate level during the year related to team resilience. Appropriate actions were taken to mitigate the risk. The risk will be reviewed in May 2016.

Which Committees have reviewed the information prior to Board submission?

- Information Governance Committee, 14/03/16
- Trust Management Executive, 16/03/2016

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Review, and to approve the proposed year-end submission

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Req No	Description	Status	Attainment Level
Information Governance Management			
13-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Reviewed And Updated	Level 3
13-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Reviewed And Updated	Level 3
13-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Reviewed And Updated	Level 2
13-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Reviewed And Updated	Level 3
13-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Reviewed And Updated	Level 3
Confidentiality and Data Protection Assurance			
13-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3
13-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	Reviewed And Updated	Level 3
13-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	Reviewed And Updated	Level 2
13-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	Reviewed And Updated	Level 3
13-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Reviewed And Updated	Level 2
13-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	Reviewed	Level 2
13-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Reviewed	Level 2
13-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Reviewed And Updated	Level 2
13-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Reviewed	Level 2
Information Security Assurance			

Req No	Description	Status	Attainment Level
13-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 2
13-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Reviewed And Updated	Level 2
13-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Reviewed And Updated	Level 2
13-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Reviewed And Updated	Level 2
13-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Reviewed And Updated	Level 2
13-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Reviewed	Level 2
13-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Reviewed And Updated	Level 2
13-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Reviewed And Updated	Level 2
13-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Reviewed And Updated	Level 3
13-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Reviewed	Level 2
13-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Reviewed	Level 2
13-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Reviewed And Updated	Level 2
13-314	Policy and procedures ensure that mobile computing and teleworking are secure	Reviewed	Level 2
13-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Reviewed And Updated	Level 2
13-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Reviewed	Level 2
Clinical Information Assurance			
13-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Reviewed And Updated	Level 2
13-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency	Reviewed And Updated	Level 2

Req No	Description	Status	Attainment Level
	requirements		
13-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Reviewed	Level 2
13-404	A multi-professional audit of clinical records across all specialties has been undertaken	Reviewed And Updated	Level 2
13-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Reviewed	Level 2
Secondary Use Assurance			
13-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Reviewed And Updated	Level 2
13-502	External data quality reports are used for monitoring and improving data quality	Reviewed	Level 2
13-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Reviewed	Level 2
13-505	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	Reviewed And Updated	Level 2
13-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Reviewed And Updated	Level 2
13-507	The Completeness and Validity check for data has been completed and passed	Reviewed	Level 2
13-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Reviewed	Level 2
13-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	Reviewed	Level 2
Corporate Information Assurance			
13-601	Documented and implemented procedures are in place for the effective management of corporate records	Reviewed And Updated	Level 2
13-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Reviewed And Updated	Level 2
13-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Reviewed And Updated	Level 2

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-19	**Summary report from Charitable Funds Committee, 22/02/16**	**Committee Chairman (Non-Executive Director)**

The Charitable Funds Committee met on 22nd February 2016.

1. The key matters considered at the meeting were as follows:

- It was confirmed that a full External Audit needed to be undertaken (rather than an "independent examination") for the 2015/16 Maidstone and Tunbridge Wells NHS Trust Charitable Fund Accounts, as a result of the value within the accounts
- The income, expenditure and balance sheet, at quarter 3 2015/16 were reviewed, along with fund transactions over £1k and the balances by individual fund. It was noted that £1.2m of income had been received for the year to date, £303k of which was not related to legacies (which is a marked increase on the previous year)
- It was noted that expenditure had also increased, and more expenditure was likely, as the Funds amalgamation project (see below) had initiated a step change in how Charitable Funds were managed and spent
- The one occasion of expenditure refused was notified, and was confirmed as appropriate
- A revised proposal for the management and administration fee for 2015/16 (of £44,753.56, including an external fee of £5,400) was approved
- Progress with the previously-agreed action to amalgamate the current list of designated Funds by Directorate was reported. The number of Funds has been reduced significantly. The Committee agreed to regard the original amalgamation project as 'closed', but that the number of funds should be reviewed on a periodic basis (and funds containing small amounts should aim to be disestablished over the next 18 months).
- A revised Policy and Procedures for Charitable Funds were approved, and it was also agreed that these did not need to be ratified again by the Policy Ratification Committee, and could just be amended (and uploaded to the Q-Pulse document management system)
- A request to transfer monies from a charitable fund (6119) to a research budget (BD580) was approved on the basis that any genuine charitable donations within fund 6119 would not be transferred

2. In addition the actions noted above, the Committee agreed that…

- The Trust Secretary should liaise with the Executive Director who would have responsibility for the communications function in the future, to ensure they took the lead on implementing the fundraising proposals that were agreed by the Committee in July 2015
- Only 3 Charitable Funds Committee meetings were required in 2016, so the meeting scheduled for 22/08/16 should be cancelled

3. The issues that need to be drawn to the attention of the Board are as follows:

- This was the last Charitable Funds Committee attended by Wendy Maher, Head of Financial Services, before she left the Trust. The Committee commended Wendy's contribution to the Charitable Funds Committee and the Charitable Fund, and was grateful for her reflections and advice to the Committee regarding the future.
- Significant level of donations had been received, funds were being spent, and there were plans for further spending
- The Trust and Committee was considering the actions that could be taken in-house to promote the Charitable Fund, and donations to the Fund

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
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Trust Board meeting - March 2016

3-20	Summary report from Audit and Governance Committee, 22/02/16	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 22nd February 2016

1. The key matters considered at the meeting were as follows:

- Revised Terms of Reference (ToR) were agreed, in response to the Committee's appointment (by the Trust Board, on 25/11/15) as the Trust's "Auditor Panel". It was noted that it was not necessary to submit the ToR to the Trust Board, for approval, given the Board's decision on 25/11/15
- The Board Assurance Framework and Risk Register were reviewed, and a number of amendments to the content were agreed, in response to challenges. It was also agreed that it should be made clear that a rating other than 'Green' in response to the question "How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?" should be accompanied by details of the further action planned
- The Internal Audit plan for 2016/17 was approved, subject to the amendments agreed at the meeting (and the Director of Finance's final judgement on such amendments)
- A Counter Fraud update was received from the Local Counter Fraud Specialist, along with an update on the actions in response to NHS Protect 'Focused Assessment' which took place in the summer of 2015. The Committee heard that progress had been made in a number of areas and the Trust would be in a much stronger position if/when NHS Protect returned for a further assessment
- A 'Progress and emerging issues report' was received from external audit, which included a benchmarking analysis of the Trust's Annual Report for 2014/15. As a result, it was agreed to include some details of the complaints received in the Annual Report for 2015/16
- The External Audit plan for 2015/16 was approved, subject to the amendment of some minor errors
- A brief update was given on the appointment of the External Auditor, from 2017/18 onwards, but it was noted that the next meeting would receive a more detailed report
- An update on the 2015/16 Accounts process was given, and the Committee approved the draft Accounting Policies, key accounting assumptions and estimation techniques (subject to any further Department of Health guidance). The Committee also confirmed the plan to prepare the Trust's 2015/16 Accounts on a going concern basis, as defined by the public sector interpretation of the requirements of the accounting standard.
- The Director of Finance gave a verbal summary of the Trust's latest financial issues
- The latest losses and compensations data was reported, as were the trends of the last 6 financial years (which showed that the trajectory had generally been downwards)
- The latest Single Tender Waivers data was received, and it was agreed to arrange for the Finance Committee to receive a regular report on the Waivers relating to breaches of the external cap on Agency staff pay rate
- A brief update was given on the Reference Costs Assurance Programme that was taking place at the Trust, but it was noted that the findings were not yet available

2. The Committee received details of the following Internal Audit reviews:

- "CQC – Patient at Risk Protocol" (which received a "Reasonable Assurance" conclusion)
- "Use of Nurse Specials" (which received a "Limited Assurance" conclusion) (see 5. below)
- "Friends and Family Arrangements" (which received a "Reasonable Assurance" conclusion)
- "Audiology Stock Management" (which not receive an Assurance conclusion as it was an Advisory review)
- "Server Management" (which received a "Limited Assurance" conclusion)
- "Information Governance Toolkit: Part 1" (it was reported that an Assurance level would be allocated following completion of Part 2)

3. **The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:**
   - "Application Management Policies & Procedures" (1 outstanding action)
   - "Data Centre Facilities Review (Frame Server Room Assessment)" (2 outstanding actions)
   - "Billing of Cardiology Activity" (1 outstanding action)

4. **The Committee agreed that (in addition to any actions noted above):**
   - The Trust Secretary should clarify whether it was acceptable for the Audit and Governance Committee to be quorate with two Non-Executive members present when acting as the Auditor Panel, and if so, amend the Committee's Terms of Reference to reflect this
   - The Trust Secretary should liaise with the Chairman of the Trust Board to request that a report on the Kent Oncology Centre partnership be received at the Trust Board
   - The process the Committee would adhere to when acting as the Trust's Auditor Panel should be documented
   - The forward programme of the 'main' Quality Committee should be amended to reflect the agreement that the "Recent findings from Internal Audit reviews" item/report should only be received every 6 months

5. **The issues that need to be drawn to the attention of the Board are as follows:**
   - The Committee felt that awaiting the outcome of the Internal Audit review of the "Use of Nurse Specials" was not a valid reason to delay the review of the "Policy and Procedure for the Use of Nurse Specials" (the Committee heard that this had been reported as part of the management response to the review's findings)

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-21	Summary report from the Quality Committee meeting, 02/03/16	Committee Chair (Non-Exec. Director)

The Quality Committee has met once since the last Trust Board meeting: a 'main' meeting was held on 02/03/16. The following issues were covered at the meeting:

- The latest **Stroke care performance** was reported. The report that was received is enclosed at Appendix 1, and has been included as a result of a previous request from the Board. The **Kent & Medway Stroke Review** was also briefly discussed, and it was noted that the Trust's Medical Director would soon meet with Medical Director for NHS England in the South East
- An update was given on progress with addressing **the clinical and non-clinical issues discussed at the Quality Committee 'deep dive' meeting on HSMR on 05/10/15.** An explanation was given for the Trust being unable to access patient-level data in the recent past, and it was confirmed that access would be reinstated from 18/03/16. The Committee heard that the issues proposed as potential areas of investigation by Dr Foster were either no longer outliers, or had improved. It was agreed that further reports only need to be submitted to the Quality Committee periodically, as and when there were any issues to report.
- The Committee received the first report from the **Trust Clinical Governance Committee** since the revised clinical governance structure had been formalised. The key issues raised were as follows:
  - The Trust Clinical Governance Committee met monthly, and Directorates provided reports on alternate months. This however posed problems in relation to the onward reporting to the Quality Committee, as the submitted report was likely to be passé
  - The main issues discussed included the recent capacity challenges, which had affected all Directorates to a degree. An equal risk was that of workforce, particularly in relation to Medical and Nurse staffing (although this was now more stable than in recent months)
  - The Trust had an ambitious target regarding recruitment to research trials, and the failure to reach the target would have implications for future funding. The Committee heard that some of the issues had arisen from staffing and governance problems within Research, but action had now been taken to address these
  - A number of Serious Incidents (SIs) had breached their deadline for investigation, although some of the breaches could be explained by the desire for an external review. This prompted a discussion on the learning arising from SIs, and it was noted that the 'SI Panel', which was now called the 'Trust Patient Safety Committee', would in future be called the "Learning and Improvement Committee", in reflection of the underlying aim of the meeting
  - The Trust had reviewed the new guidance from NHS England and the NHS Trust Development Authority and a new Mortality Surveillance Group had been constituted, with a broader membership that the previous Mortality Review Group. Mortality Review Forms had been revised, and would soon be issued to Directorates. For Medicine, which had the largest number of deaths, 1 in 5 deaths would be reviewed, but reviews would always occur for cases linked to Coroners' Inquests. All other Directorates would need to review all the deaths that occurred. Additional central data analysis support had been obtained, but did not negate the need for Directorates to undertake their own analysis
  - The Clinical Director for Trauma and Orthopaedics reported that elective Orthopaedic activity had all but ceased, as a result of bed pressures. It was also brought to the Committee's attention that the experience of trainees and Trauma & Orthopaedics and Surgery was very poor and that this could be expected to have a negative impact on attracting trainees and potential Consultant applicants in the future.
  - The Clinical Director for Critical Care also reported that they had major staffing concerns and there were issues with Junior Doctors' rotas, and that 2 'hot' sites (with 2 A&Es) was potentially unsustainable. There was general consensus for clinical colleagues that escalation was causing grave concerns. The positive impact of the 38 beds from the new Ward at Tunbridge Wells Hospital was acknowledged, but a discussion was held on the merits of ring-fencing beds, to ensure elective activity was maintained.

- A discussion was held as to whether the **information now being provided the Quality Committee** was sufficient to enable the Committee to fulfil its duties. Although the need to allow the new process time to develop was acknowledged, it was felt that the level of information provided at the meeting had been insufficient. It was therefore agreed that future reports from the Trust Clinical Governance Committee should include reference to, and evidence from, Directorate Clinical Governance meetings; and Directorate's use of nationally available quality data
- The Committee received a report providing the **findings from, & participation in, National Clinical Audits**. It was noted that the Trust Clinical Governance Committee had already agreed that a detailed review be undertaken of the national clinical audits in which the Trust participated, and that recommendations be made as to which audits the Trust should no longer participate in. It was therefore agreed that this action should be allowed to proceed, but that the Quality Committee should receive a further report on the findings from each of the national clinical audits in which the Trust currently participated
- The **next steps to be taken regarding patient falls** were reported, following the Quality Committee 'deep dive' meeting into falls that was held in January 2016
- The latest **SIs** were considered, and the Clinical Director for Trauma and Orthopaedics pointed out that fractures of neck of femur could cause, rather than occur as a result of, a fall. It was therefore agreed that it may be beneficial for the X-Rays taken for falls involving fractures to be reviewed, to determine whether the fracture may have caused the fall, rather than vice versa
- The latest situation regarding **Catheter Associated Urinary Tract Infections** was reported, and assurance was given that the CQUIN was fully expected to be achieved at year-end
- An update on **visits from external agencies** was received, but it was agreed that the Quality Committee would no longer receive future reports on visits from external agencies.
- The minutes of the **Quality Committee 'deep dive' meetings** held on 11/01/16 and 01/02/16 were received
- The **recent findings from Internal Audit reviews** were reported, and it was noted that in future, such reports would only be provided every 6 months
- An update on **Reputational risk issues** was received, but it was agreed that the Quality Committee would no longer receive future reports on reputational risk
- The Committee heard that the PACS system had been unavailable for 40 minutes on the morning of the meeting, and agreed that the Medical Director should arrange for an **overview of IT system failures/downtimes** to be reported the Trust Management Executive. It was also agreed that the Medical Director should clarify the process in place for ensuring that IT system failures/downtimes are reported/logged centrally. The role of the Quality Committee in in relation to the impact of such incidents on quality was emphasised.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Appendix 1: Update on Stroke care performance

Maidstone and Tunbridge Wells NHS
NHS Trust

QUALITY COMMITTEE - MARCH 2016

3-5	UPDATE ON STROKE CARE PERFORMANCE	CLINICAL DIRECTOR, EMERGENCY AND MEDICAL SERVICES

The enclosed report provides information on:

- Current stroke performance against national benchmarks
- Actions being taken to maintain and further improve standards

Reason for receipt at the Quality Committee (decision, discussion, information, assurance etc.)
Information and assurance

1. Introduction

Following the initial Quality & Safety Committee's 'Deep Dive' into the Trust Stroke services in July 2014, updates have been requested and produced for presentation at each Quality Committee. This provides both an update on the transformation of stroke services across the Trust in addition to regional benchmarking. The paper also allows assurance on the quality of care being delivered within the Trust. As from May 2015, a more compact report showing Stroke headlines was requested to replace the full paper. This is the fifth short headline paper to be presented to the Quality Committee.

2. Performance Standards

Information is now collected monthly by the Trust to give internal assurance about delivery against the Sentinel Stroke National Audit Programme (SSNAP). The Trust continues to review its own targets to continue to drive improvements within stroke care, adhere to national standards and drive excellence in stroke care.

2.1 CT scan performed in under an hour:

- December data for scanning within 1 hour has continued to be successful with Tunbridge Wells Hospital (TWH) scanning 68% within the hour and Maidstone (MH) scanning 64.1%. The national average remains static at 47.4% with a SSNAP "A" Level requiring 48% of patients to be scanned with an hour. Both sites are significantly above this target.
- 12 hour scanning shows a rewarding outcome with TWH scanning 100% within 12 hours and MH remaining consistent at 97.4%. National average currently sits at 91%, with a Level A consisting of 95% of patients being scanned within 12 hours. Both sites have shown they are performing well in the upper quartile for this target.
- SSNAP results covering data collected October – December 2015 has not yet been reported but should indicate a high performance within imaging cross site.

2.2 Proportion of all stroke patients given thrombolysis (all stroke types) and 2.3 Percentage of thrombolysed patients with a door-to-needle time <60mins is as follows:

- December data indicates that there was a significant 16% of patients' thrombolysed at TWH. The month saw 50% thrombolysed within 60 minutes.
  - At MH a significant increase to 15.4% of patients were thrombolysed, which equated to 6 patients, 3 of whom achieved the 60 minute door to needle target.
- Thrombolysis rates and the 60 minute door to needle target consistently remains a challenge, However December saw a surge in eligible patients to receive the treatment with fluctuating results which is reassuring.
- SSNAP Results covering data from October – December 2015 is expected to show a mixed picture of performance throughout the quarter.
- Ensuring there are highly trained nurses available on the stroke bleep is paramount. Currently there are challenges regarding stroke nurse bleep holders due to the national shortages in nurses, with key individuals requiring further training to perform the role. It is not an option to train newly qualified nurses due to the skills required of the nurses. The higher skilled the nurse and stroke team the quicker the Door to Needle is likely to be, dependent upon complications and contra-indications.

2.4 Proportion of Patients admitted to the stroke unit within four hours:

- December data within this performance indicator shows that MH admitted 56.4% of stroke patients to the stroke unit within 4 hours. TWH showed a further drop to 32% from 38.5% In November. This target is heavily reliant on having a stroke ring fenced bed, however on occasions medical patients have been placed in the stroke ring fenced beds due to bed pressures, meaning that when a stroke attends A&E they are unable to access the ring fenced bed within 4 hours. This is more likely to occur at TWH due to there only being 10 acute stroke beds. It is expected that when stroke rehab returns to the main site in March that there will be a significant increase in this target and therefore associated Best Practice Tariff.

2.5 Assessment by a stroke physician within 24 hours:

- Monthly data from December indicates specialist assessments were completed within 24 hours in 60% of cases at TWH and 76.9% at MH, which shows a stable performance at TWH since the drop in November due there not being a locum stroke physician in post and only one stroke physician. Maidstone showed an improved performance at 76.9% of patients being seen within 24 hours.

2.6: Current 80/90 Performance

- December data is currently 76.8% with a current year to date (YTD) performance of 81.3%. The national average for this indicator has increased from 84% to 86.1%. As expected there has been a significant reduction in December and January data (64%) due to a large a large number of strokes being admitted in a short time frame, and patients having to move off the stroke unit to make acute beds, therefore having their stroke pathway fail. The Lead stroke nurse is monitoring the 80/90 target, and validating the data to secure the target, however limiting moves, moving medical patients off the stroke unit and ensuring a ring fenced bed is available is key to achieving this.

2.7: CQUIN achievement for 15-16

- The new CQUIN for 15-16 has been agreed which is focused upon Early Supported Discharge (ESD) use to reduce Length of stay (LOS). A working party has been formed to identify steps to assist in achieving the required outcome.

3. Conclusion

Data has generally showed some significant improvements. Work continues locally with site specific action plans and meetings taking place to improve performance and drive up standards of care. The Kent Stroke Review continues to progress, with both nursing and medical clinical leads in addition to a strategic representative attending the Clinical Reference group to represent the Trust. Options are currently being identified and presented to the CCGs which may result in public consultation by March/April 2016. The options of 3, 4 and 5 combined Hyperacute and acute units throughout Kent have been accepted by the Programme board and are currently having in-depth analysis of each option.

Below is a reminder of Kent's SSNAP results for April – June 2015 and July - September 2015 which is encouraging for benchmarking. This placed MH and TWH as the third and fourth highest performing units in Kent just under Queen Elizabeth and the William Harvey with TWH close to entering the SSNAP Level C band (60 points required). The data for October – December 2016 will be available to report on by the next Q&S committee.

April – June 2015

- Queen Elizabeth SSNAP Level C (64.1 points)
- Maidstone SSNAP Level C (63.7 points)
- Darent Valley SSNAP Level C (62.3 points)
- William Harvey SSNAP Level C (60.8 points)
- TWH SSNAP Level D (57.9 points)
- Kent and Canterbury SSNAP Level D (47 points)
- Medway Maritime SSNAP Level D (43.7 points0

July – September 2015

- William Harvey SSNAP Level B (70.3 points)
- Queen Elizabeth SSNAP Level C (68.4 points)
- Maidstone SSNAP Level C (63.7 points)
- TWH SSNAP Level D (58.9 points)
- Darent Valley SSNAP Level D (57 points)
- Kent and Canterbury SSNAP Level D (55.6 points)
- Medway Maritime SSNAP Level D (46.5 point)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-22 Workforce Committee Report — Cttee. Chair, Non-Executive Director

This report provides a summary of the issues discussed at the Workforce Committee on 03 March 2016.

NHS Staff Survey 2015

A presentation was given on the Trust results from the 13th annual national NHS staff survey that took place between September and December 2015. The findings were presented in context against the national and local picture. The overall results are good but there are some areas that the Trust needs to continue to focus on:

- Address equality and diversity issues from the point of view of staff and patients.
- Staff engagement.
- Health and wellbeing for staff

Listening into Action (LiA)

The Committee received a report on a proven staff engagement tool which the Trust is currently exploring as an approach to further improve staff engagement.

Statutory and Mandatory Training

The Committee received a report outlining the current level of compliance against each subject and movement since the September 2015 report. Overall statutory and mandatory training compliance continues to increase. In April 2016 the Board compliance figure will be extended to reflect all subjects and not just the agreed core subjects. This will result in a slight drop below target in total Trust compliance reported in the monthly dashboard, however will provide the full picture of all Trust mandatory subjects.

Junior Doctors – the New 2016 Contract

The report provided information on the main changes of the new contract and timetable for implementation. The British Medical Association (BMA) has already announced three 48 hour strikes and plans to launch a judicial review against the government's plan to impose the new contract.

Medical Education Update

The report provided information on medical education and training programmes in the Trust and highlighted that the Trust is recognised as excellent training environment as evidenced by recent allocation of additional training posts in Medicine and Paediatrics. The report detailed a number of projects that are underway including:

- Physicians associates
- Multi-professional mentoring
- Multi-professional project using the WHO patient safety modules
- Improvement for handover
- Medical induction

Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles

The Committee received a copy of the final report. The report highlighted potential efficiency opportunities within the workforce when compared to the 'model efficient hospital'. The Carter Team are undertaking further work to establish how to provide comparable data to providers to enable the formation of local plans. On completion of the review of the recommendations and receipt of the detailed comparable data, the Trust will develop an action plan which will be presented to both the Workforce Committee and the Finance Committee.

New Rostering System
The Committee received a report on the current rostering system and replacement plan following business case approval. Pending business case approval, the Committee will be provided with a more detailed presentation of the system and implementation plan.

TDA Workforce Plan – 1st Submission
The report provided information on the first submission of the workforce plan to the TDA.

New Starters Survey
The Committee received a report on the experience of new starters in the Trust following the implementation of a new online survey. Overall the results are positive but work is needed on Trust Induction and health and wellbeing for staff.

Workforce Risk Register
The 3 principal risks relating to the workforce are:

1. Recruitment and retention
2. Temporary staffing
3. Culture including employee engagement.

The report provided information on the key workforce risks, current controls and planned actions to mitigate the risks. The Committee agreed the 3 key risks and expressed enthusiasm for the use of a cultural barometer to monitor progress.

Workforce Performance Dashboard
The Committee received a report on the workforce dashboard which highlighted the issues of temporary workforce and vacancies.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information.
Assurance.

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2016

3-23	Summary report from the Patient Experience Committee meeting, 07/03/16 (incl. revised ToR)	Committee Chair (Non-Executive Director)

A Patient Experience Committee meeting was held on 7th March 2016. The issues covered, and the actions agreed, were as follows:

- The **Terms of Reference**, which were due their annual review, were reviewed. A number of minor / 'housekeeping' changes had been proposed, and were agreed. The revised Terms of Reference, which the proposed changes 'tracked', are enclosed at Appendix 1, for approval
- An **update on translation services** was given, and it was noted that a new service, via a new provider, would be introduced shortly. The Committee heard that the new service would have significant benefits for staff, patients and finances, and would be far more responsive than the current service. The booking process would also be more efficient, and the new service was estimated to result in a saving of £50k per year. It was agreed that a further update would be submitted to the Committee in June 2016
- An **update on Stroke Services** was given (via the same report that had been submitted to the 'main' Quality Committee on 02/03/16), and it was agreed to receive a further update at the June 2016 Committee meeting
- The Deputy Chief Nurse submitted a **response to the issues raised by the Junior Doctor who attended the Committee on 07/12/15** (i.e. patients experiencing isolation as a result of the single room environment at Tunbridge Wells Hospital (TWH); relatives being unable to identify the profession of staff members; the potential use of a 'dementia friends' system; and the impact of Ward moves, due to bed capacity). The Committee was generally assured by the responses given, but it was agreed that the feasibility of introducing a colour-coded ID badge scheme, to enable staff members' profession to be identified, would be investigated; and that consideration should be given as to whether a monitoring system could be introduced, to provide evidence that Nursing staff were entering patient rooms at TWH to check patients' status The Deputy Chief Nurse was also asked to liaise with the Junior Doctor who had raised the concerns, as they had been unable to attend the meeting.
- The latest **Complaints and PALS contacts data** was reviewed, and assurance was given that the new Complaints process had been successful
- An update on the latest activity of **Healthwatch Kent** was given by the Healthwatch representative. It was agreed that the Deputy Chief Nurse would liaise with Healthwatch Kent officers to identify the issues preventing the occurrence of the 'Enter and View' visit to Outpatients (and resolve such issues if possible). It was also agreed that the Healthwatch representative would arrange for the report of the previous 'Enter and View' visit to Ophthalmology to be submitted to the Committee
- Progress on the **Quality Accounts patient experience priorities for 2015/16** was reported, and **proposed quality priorities for 2016/17** were submitted, for discussion (though no comments and/or suggestions were forthcoming)
- Progress with the implementation of the action plan relating to the latest **Patient Led Assessments of the Care Environment (PLACE)** was reported, which included an **update on the mealtime support being given to patients**. It was reported that as the current food delivery system at Maidstone Hospital did not accommodate the red trays the Trust had used previously, a system that used red dots (to notify staff) and red napkins (to indicate patients who needed support) had been trialled. The Committee heard that review of the trial had identified that there was variability in the usage of red dots, and in the provision of red napkins, but in general, patients were receiving the support they required. It was also reported that the Trust was working with the supplier of the red trays, to obtain trays that fitted the new food trollies, but the supplier required a minimum order of 1000 (as the new trays were bespoke). The discussion led to a challenge as to whether the new system was working effectively, & the critical observations arising from Ward visits by some Committee members resulted in an agreement to submit a report on the latest situation to the Committee in June.

- **Planned and recent service changes** were reported, which included the new inpatient Ward at TWH; the new John Day Ward at Maidstone Hospital; clarification of the position regarding Medway NHS Foundation Trust / Swale Clinical Commissioning Group (CCG); Crowborough Birthing Centre, and related community care; the introduction of Virtual fracture clinics and Outpatient 'Propess'; the Kent Transforming Pathology Service; and developments in Cancer (including the new Linear Accelerator in Canterbury)
- A report from the representative from **West Kent CCG** was noted, which included notification that the new Kent and Medway patient transport service would start 01/07/16. It was agreed that the next update from the CCG should include further details of that service
- The usual update on **Communications and Membership** was given, and it was agreed consider the appropriateness, in terms of accessibility, of the use of colour within the "Patient First" magazine (as concern was expressed that the use of multi-coloured pages in the magazine had an adverse effect on readability for patients with certain eye problems)
- The latest findings from the **local patient survey (incl. Friends and Family)** were discussed, which highlighted that: overall satisfaction had not improved significantly in the last Quarter; noise at night had seen an improvement; performance re being able to talk to staff about treatments was stable, but medication side effects performance was still not at the level required by the Trust. The report also highlighted that call bell response times remained good overall, but patient perception of response times had deteriorated. The overall response time included some responses above 30 minutes, but it was explained that this related to the way specific areas operated, in that staff responded initially, but then tripped the alarm again, so that it would remain in place until the matter was fully resolved. This practice did however often lead to perceptions from some patients that call bells were not receiving a response
- A report was received from the **Patient Information and Leaflets Group (PILG)** (the Committee's only sub-committee), which noted that 28 leaflets had been updated since the last report, and the backlog of publishing leaflets had reduced to 16 at the time the report had been written (and would be zero by the time of the next meeting). It was noted that the next priority was to ensure that every leaflet on the database had been subject to PILG ratification, and had been reviewed by patient representatives
- The summary reports of the last 3 meetings of the **Quality Committee** were received, and following a brief discussion regarding End of Life Care, it was agreed to circulate the Trust's current Policy for End of Life Care to Committee members. It was further agreed to liaise with the Chief Nurse, to consider whether it would be appropriate for the Committee to receive a presentation on End of Life Care at a future meeting
- An update on the review of the **Care Assurance audit process** was reported, and the intention to make the assessment process less onerous, with less documentation, was noted. It was reported that the new process would likely be in place in the next 4-6 weeks. Following comments by some Committee members, the Deputy Chief Nurse agreed to investigate the whereabouts of the previous reports submitted by those undertaking Care Assurance audits.
- Finally a query was raised under AOB as to Trust's arrangements for **Safeguarding Adults.** The Deputy Chief Nurse gave assurance that although there had been some concerns in relation to Deprivation of Liberty Safeguards (DOLS) (partly as a result of the Kent County Council DOLS office being overwhelmed with applications) that he did not believe there was a major concern.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

1. To approve the revised Terms of Reference for the Patient Experience Committee (Appendix 1)
2. Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS
NHS Trust

PATIENT EXPERIENCE COMMITTEE

TERMS OF REFERENCE

1. Purpose

The Committee's purpose is to

1. Present the patient and public perception of the services delivered by Maidstone and Tunbridge Wells NHS Trust, and
2. Monitor any aspect of patient experience, on behalf of the Trust Board (or at the request of any Board sub-committee or other relevant Trust committee)

2. Membership

From the Trust:

- Non-Executive Director (Chair)
- Non-Executive Director (Vice~~Deputy~~ Chair)
- Chief Nurse
- Director of Finance
- Deputy Chief Nurse
- Associate Director for Quality~~,~~ Governance ~~& Patient Safety~~
- ~~Patient Experience Matron (x2)~~
- Complaints & PALS Manager

External to the Trust:

- Public representatives from the Trust's catchment area
- Representatives from patient and carer support groups within the Trust's catchment area
- Representative from Healthwatch Kent (1)
- Representative from the local Independent Health Complaints Advocacy service (1)
- Representative from the League of Friends of the Maidstone Hospital (1)
- Representative from the League of Friends of Tunbridge Wells Hospital (1)

3. Attendance and quorum

The Committee will be quorate when 4 members from the Trust, including 1 Non-Executive Director, and 4 members external to the Trust are present. Members may request a deputy to attend meetings in their place. Such a deputy will count towards the quorum.

All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors are entitled to attend any meeting of the Committee.

A representative from the 'Doctors in training' (J~~j~~unior D~~d~~octors) at the Trust will be invited to attend each meeting, and provide a report on their reflections of the patient experience-related matters relevant to their role.

A representative from West Kent Clinical Commissioning Group (CCG) will be invited to attend each meeting, and provide a report on relevant matters.

The Chair/s of the Patient Experience Committee's sub-committees will be invited to attend certain meetings, to provide a report on the sub-committee's activity.

The Committee Chair may also invite others to attend, as required, to meet the objectives of the Committee

4. Frequency of meetings

Meetings will be generally held quarterly.

Additional meetings will be scheduled as necessary at the request of the Chair.

5. Duties

- To positively promote the Trust's partnership with its patients and public
- To provide the perspective of patients and the public and to present the patients' and public's perception of the Trust's services
- To oversee the development of patient information within the Trust, via the Patient Information Leaflet Group (PILG)
- To contribute to the development of Trust Policies and procedures, in so far as they relate to patient experience
- To advise on priorities for patient surveys and on the methods for obtaining local patient feedback
- To act as the primary forum by which the Trust will involve and consult with its patients and public on:
  - The planning of the provision of its services
  - Proposals for changes in the way those services are provided, and
  - Significant decisions that affect the operation of those services
- To monitor (via the receipt of reports) the following subjects:
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent 'Enter & View' visits (with a response, if relevant)
  - Comments from NHS Choices/'My NHS', and Social Media
  - Complaints information
  - PALS contacts information
  - Progress against the "Patient Experience" priorities in the Trust's Quality Accounts
  - Patient experience-related findings from Patient-led Assessments of the Care Environment (PLACE)
  - Patient experience-related findings from Care Assurance Audits (including reports from external members of the Committee)
- To review the work being undertaken by Clinical Directorates in relation to patient experience

6. Parent committees and reporting procedure

The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chair~~man~~ will report its activities to the next Trust Board meeting following each Patient Experience Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive members to each meeting of the Committee, by exception.

The Committee's relationship with the Quality ~~& Safety~~ Committee is covered separately, below.

7. Sub-committees and reporting procedure

The following sub-committees will report to the Patient Experience Committee through their respective chairs or representatives following each meeting:

- Patient Information Leaflet Group (PILG)

The frequency of reporting will depend on the frequency of sub-committee meetings.

8. Quality ~~& Safety~~ Committee

The Quality~~ & Safety~~ Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request

that the Quality ~~& Safety~~ Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality ~~& Safety~~ Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality ~~& Safety~~ Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality ~~& Safety~~ Committee.

9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

10. Emergency powers and urgent decisions

The powers and authority of the Patient Experience Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Patient Experience Committee, for formal ratification.

11. Review

The Terms of Reference of the Committee will be agreed by the Patient Experience Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

- Terms of Reference (amended) agreed by the Patient Experience Committee, 14th October 2009
- Terms of Reference (amended) agreed by the Patient Experience Committee, 4th October 2010
- Terms of Reference (amended) approved by the Patient Experience Committee, 3rd October 2011
- Terms of Reference (amended) agreed by the Patient Experience Committee, 6th February 2012
- Terms of Reference (amended) approved by Patient Experience Committee, 7th March 2013
- Terms of Reference (amended) approved by the Trust Board, 29th April 2015
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2016
- Terms of Reference (amended) approved by the Trust Board, 23rd March 2016

Maidstone and Tunbridge Wells NHS
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Trust Board meeting – March 2016

3-24	Summary of the Trust Management Executive (TME) meeting, 16/03/16	Chief Executive

This report provides information on the TME meeting held on the 16th March 2016. The meeting was not a 'usual' TME, and was actually a joint meeting with the Trust Board, which focused on the plans for 2016/17.

Presentations on such plans were given for the all Clinical Directorates, and for Estates and Facilities Management and Health Informatics.

Each presentation covered the following themes:

- Intentions
- Issues and mitigation
- Future opportunities
- Risks

Copies of the presentations have been circulated to all Trust Board Members.

The meeting also included a brief discussion, led by the Chief Operating Officer, on the configuration of capacity, following the opening of the new Ward at Tunbridge Wells Hospital.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

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Trust Board Meeting – March 2016

3-25	Summary report from Finance Committee, 21/03/16	Committee Chairman (Non-Executive Director)

The Finance Committee met on 21st March 2016.

1. The key matters considered at the meeting were as follows:

- The "Safety Moment" proposed that the Trust Board debate the ring-fencing of elective activity. It was agreed that a debate should occur at the Part 2 Board meeting on 23/03/16
- Month 11 financial performance was examined. As usual, the written reports were supplemented by a presentation, which included the forecast out-turn for 2015/16. The Director of Finance expressed confidence that the planned deficit of £23.5m would be met
- The Chief Executive submitted a brief report on the Trust's plans in relation to patients who wished to self-fund their care after discharge from hospital, and assurance was given that the actions would have a positive effect in early 2016/17
- A report on Nursing establishments was submitted, and it was noted that such establishments were being reviewed as part of the budget setting process, and would be subject to a series of challenge meetings before being finalised. It was agreed to arrange for a representative from a clinical area (selected by the Director of Finance) to attend the Committee in June 2016, to discuss their establishment
- A progress report on the Trust's 2016/17 planning process was scheduled to be discussed, but was not available for discussion. It was therefore noted that a detailed discussion would be held at the Trust Board on 23/03/16
- A report on the Lord Carter efficiency review and Service Line Reporting opportunities was discussed. The size of the potential values associated with the opportunities was noted.
- A report on the financial aspects of the latest Risk Register was noted
- The Director of Health Informatics attended to give a report on the Trust's IT strategy and related matters (which included a review of the transfer of the KMHIS, and outstanding Internal Audit actions). The need to prioritise IT developments in the context of the Trust's wider strategic priorities was acknowledged, and it was agreed to circulate the architectural 'road map' for the INSPIRE strategy to Finance Committee members
- The latest Committee evaluation findings were received, and a discussion was held regarding the scheduling of future Finance Committee and Trust Board meetings. It was agreed that the matter would be discussed at the Trust Board on 23/03/16

2. In addition the agreements referred to above, the Committee agreed that:

- Future monthly financial information submitted to the Committee should include the relationship between activity, Whole Time Equivalent worked, and expenditure
- Further analysis of Agency staff usage (including examples of the Agency staff that had been engaged) should be submitted to the Finance Committee in April
- The Director of Finance should consider the appropriateness of the identified Leads for the 15 Project Teams being established to respond to the headline recommendations from the Lord Carter efficiency review
- The Trust Secretary should submit a brief report to the Trust Board on 23/03/16 outlining the benefits and implications of changing the dates of Trust Board meetings
- The Director of Finance should submit a briefing on the PFI contract for Tunbridge Wells Hospital to the Committee in September 2016

3. The issues that need to be drawn to the attention of the Board are as follows:

- It was agreed that the ring-fencing debate should take place at the Part 2 Board on 23/03
- The importance of the review of Nursing establishments and the need to rigorously manage nursing staff costs in 2016/17
- It was agreed to arrange for the scheduling of future Finance Committee and Trust Board meetings to be discussed at the Trust Board on 23/03/16

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.)

Information and assurance